CASCADE INTERNAL MEDICINE SPECIALISTS

Authorization to Use/Disclose Protected Health Information

Patient Name: ________________________ Date of Birth: ______________

Address: _____________________________________ Phone: __________________

I HEREBY AUTHORIZE: (name of person or facility which has information)	**TO RELEASE TO:** (name of person or facility to receive information)
Provider Name: ___________________________	**Provider Name:** ___________________________
Facility Name: ___________________________	**Facility Name:** Cascade Internal Medicine Specialists
Address: ______________________________ ____________________________________	**Address:** 2239 NE Doctors Drive, Ste 200 Bend, OR 97701
Phone: _________________ **Fax:** ______________	**Phone:** (541) 318-0124 **Fax:** (541) 318-0188

Please specify the health information you authorize to be released:

☐ All Medical Records ☐ Labs/Pathology ☐ Diagnostic Imaging
☐ Immunizations/Vaccinations ☐ Billing/Insurance

Records are needed for continuity of care

If the information to be disclosed contains any of the types of records or information listed below, the laws relating to this information may apply. I understand that this information will be disclosed if I **place my initials** in the applicable space next to the type of information;

______ HIV/AIDS Information ______ Mental Health Information
______ Genetic Testing Information _____ Drug/Alcohol (Diagnoses, treatment, or referral information)

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

Provider Information: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization form. Any use or disclosure already made with your permission cannot be undone. To revoke please send a written statement to Clinical Manager, Cascade Internal Medicine Specialists@ 2239 NE Doctors Drive, Suite 200, Bend, OR 97701. Verbal revoking of authorization will not be accepted.

I have read this authorization and I understand it: ______________________________Date_______________

(Signature of patient, parent or representative)

Description of personal representative authority: ____

Unless revoked this authorization will expire: **One year from signature date**