AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I Authorize: ____

NAME OF INDIVIDUAL or ENTITY DISCLOSING INFORMATION (Exp: Medical Provider/ Facility Name)

Address: ____

Phone: __________________________________ Fax: _________________________________

to use and disclose the specific health information described below regarding:

_______________________________________ _________________________________

PATIENT NAME DATE OF BIRTH

Information to be disclosed:

___Billing Statement ___Diagnostic Imaging Report(s)

___Clinical Record(s) ___Laboratory Report(s)

___Cosmetic Records(s) ___Pathology Report(s)

___Other____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree 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

_____ Alcohol/Chemical Dependency diagnosis, 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 and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION: You may revoke this authorization in writing at any time. If you revoke you're authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to the Medical Records Dept. at Deschutes Dermatology Center -325 SW Upper Terrace Dr., Bend, OR 97702 and state you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked, this authorization expires (insert either applicable date or event):________________or after 90 days from signature.

By:____ Date: ____________________________

INDIVIDUAL OR PERSONAL REPRESENTATIVE

Description of personal representative's authority:

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