

DESCHUTES DERMATOLOGY CENTER
325 SW Upper Terrace Dr
Bend, OR 97702
Office (541) 330-0900 Fax (541) 312-5739

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____
NAME OF INDIVIDUAL or ENTITY DISCLOSING INFORMATION

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

PATIENT NAME DATE OF BIRTH

TO: _____
NAME, ADDRESS PHONE/ FAX NUMBER

Information to be disclosed:

- | | |
|--|---|
| <input type="checkbox"/> Billing Statement | <input type="checkbox"/> Diagnostic Imaging Report(s) |
| <input type="checkbox"/> Clinical Record(s) | <input type="checkbox"/> Laboratory Report(s) |
| <input type="checkbox"/> Cosmetic Records(s) | <input type="checkbox"/> Pathology Report(s) |
| <input type="checkbox"/> 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 your 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:
