

# AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: **ORTHOPEDECS NORTHWEST** to use and disclose a copy of the specific health information described below:

**Patient's Name** \_\_\_\_\_

First Name

M.I.

Last Name

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Contact Ph#:** \_\_\_\_\_

**The purpose of this release is for:**    Personal Records       Follow-up care       Diagnostic evaluation

Legal\*       Reimbursement       Other \_\_\_\_\_

**By marking the boxes below, I specifically authorize the release of the following:**

Chart Notes     Lab Reports     Diagnostic Imaging Reports     X-ray films\*\*     Billing Statements

Other \_\_\_\_\_

\*There may be a charge for copying your records. \*\*If you are requesting the release of x-rays, please be advised that originals are part of your permanent medical records. You may purchase copies for personal use.

<b>I authorize information FROM:</b>	<b>Please SEND my records TO:</b>
<b>Name:</b>	<b>Name:</b>
<b>Address:</b>	<b>Address:</b>
<b>City/ST/Zip:</b>	<b>City/ST/Zip:</b>
<b>Phone#                      Fax#</b>	<b>Phone#                      Fax#</b>
<b>Permission to Fax information    <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>	<b>Permission to Fax information    <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>

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
- \_\_\_\_\_ Sexually transmitted disease 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 restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to disclosure.**

**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 Privacy Officer at Orthopedics Northwest, 15755 SW Sequoia Pkwy, #200, Tigard, OR 97224.

**SIGNATURE: I have read and understand this authorization. Unless revoked, this authorization expires one year from the date of this signed form.**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Personal Representative)

Description of Personal Representative's Authority: \_\_\_\_\_