AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION I authorize: _____
(NAME OF INDIVIDUAL/ENTITY DISCLOSING INFORMATION)

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

_____ _____
(NAME OF INDIVIDUAL) (DATE OF BIRTH)

consisting of:_____

_____
(DESCRIBE INFORMATION TO BE USED/DISCLOSED)

to: _____
(NAME AND ADDRESS OF RECIPIENT OR RECIPIENTS)

for the purpose of: _____

_____
(DESCRIBE EACH PURPOSE FOR DISCLOSURE)

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 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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

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 our Attn: Inovia Medical Records 2200 NE Neff Rd Suite 204 Bend, OR 97701 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)

By:_____ Date:_____
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority:

_____