Authorization for Use and Disclosure of Protected Health Information

PHYSICIAN RECEIVING INFORMATION:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

PATIENT IDENTIFICATION:

Name: _____ Date of Birth: __/__/__

Address: _____

_____

Social Security #: _____ Phone: _____

PHYSICIAN RELEASING INFORMATION:

Cascade Orthopaedic Group
Drs. Tamara S. Simpson, Patrick A. Dawson,

6485 S.W. Borland Rd., Suite A
Tualatin, Oregon 97062
Phone: 503 692-5483
Fax: 503-691-2757

DATES OF HEALTHCARE TO BE RELEASED:

From (date): _____

To (date): _____

From (date): _____

To (date): _____

PURPOSE OF REQUEST:

_____ Treatment or consultation _____ At the request of the patient _____ Billing or claim payment

Other: _____

TYPE OF INFORMATION TO BE RELEASED:

_____ Emergency room report _____ Laboratory test reports _____ X-ray reports

_____ Operative report _____ History & Physical exam _____ X-ray films / images

_____ Discharge Summary _____ Consultation reports _____ Itemized bill

Other: _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this application, at any time I can revoke this authorization by submitting a notice in writing to Cascade Orthopaedic Group. Unless revoked, this authorization expires in 180 days or on the following date or event: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing and/or treatment, I agree to its release. ☐ YES ☐ NO _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ☐ YES ☐ NO _____ Initials

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that my doctor may not condition my treatment on whether I sign this authorization form unless specified above under PURPOSE OF REQUEST. I can inspect or copy the protected health information to be used or disclosed.
I authorize Cascade Orthopaedic Group to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Relationship if not the patient: _____