Authorization for Use or Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth: _____
Other Name(s) Used: _____ Phone: _____
Address: _____ Alt. Phone: _____
City:_____
State:_____ Zip Code:_____

As indicated below, I authorize Hope Orthopedics of Oregon

☐ to release my protected health information **to**:
Name: _____
Address: _____
City:_____
State:_____ Zip Code:_____

☐ to obtain my protected health information **from**:
Name: _____
Phone: _____
Fax: _____

Information to be released or obtained, from treatment dates: _____ to: _____ for the following purpose(s):

☐ Personal Use ☐ Insurance ☐ Second Opinion
☐ Changing Physicians ☐ Legal ☐ Worker's Compensation
☐ Continuing Care ☐ School ☐ Other_____

Information to be released or obtained, from treatment:

☐ Billing Statement ☐ Entire Medical Record ☐ Imaging Film (X-ray, MRI, etc.) ☐ Other_____
☐ Consultation Report ☐ History and Physical Exam ☐ Lab Report
☐ Discharge Summary ☐ Imaging Report ☐ Operative Report

This authorization is :

☐ Limited to a worker's comp claim for the injuries ☐ This authorization will expire (date/event)_____ or once this request has been fulfilled.

Method in which you wish to receive records:

☐ CD ☐ Paper Copy ☐ Patient Portal ☐ Other_____

If the information to be used/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 used or disclosed if I place my initials in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment or referral information _____ Mental Health Information - Including provider notes
_____ HIV/AIDS information

I understand that: I may revoke this authorization at any time by notifying Hope Orthopedics at the address below, in writing, and this authorization will cease to be effective on the date received, but is NOT retroactive to release of information made in good faith. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS related information and psychiatric/mental health information. A photocopy of this form will be considered as valid as the original. My refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment. Any charges for copies must be paid prior to release of copies.

The undersigned hereby releases the above-mentioned institution from any liability which may arise from release and/or examination of the information indicated above.

Signature of patient or legal representative: _____
Relationship to patient: _____ Date:_____

Medical Records Dept., Hope Orthopedics of Oregon, 1600 State St., Salem, OR 97301, 503.540.6300