Pain Consultants of Oregon

Our family of companies:
Pain Consultants of Oregon
Middle Fork Surgery Center
Oregon Analytic Laboratories
Pain Research of Oregon

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Authorization to Use/Disclose Health Information

Patient Name (print) _____ Date of Birth _____

I authorize Pain Consultants of Oregon to disclose a copy of the specific health information I have described consisting of *(describe information to be used and disclosed induding dates of treatment)*:

_____

For the purpose of *(describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose)*:

_____

Send the information to:

_____

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
_____ Genetic testing information
_____ Mental health information
_____ Drug/alcohol 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 and drug/alcohol diagnosis, treatment or referral information.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed authorization unless your health care or treatment is for the purpose of creating health information about you to be disclosed to a third party; or for the purpose of research.

You have the right to revoke this authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this authorization, please send a written statement to the privacy officer at Pain Consultants of Oregon at the address listed at the top of this form. Include the date you signed this authorization, the recipient of the information identified in the authorization and state that you are revoking this authorization.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient Signature _____ Date _____
(or authorized representative) *(expires in 180 days)*

Description of Representative's Authority _____
(if applicable)