

Bend Spine and Pain Specialists

2041 NE Williamson Ct. Suite B
Bend, Oregon 97701
Phone (541) 647-1645 Fax (541) 647-1648

I, _____ SS# _____ DOB _____
(patient name)
Authorize **Bend Spine and Pain Specialists** to use and/or disclose my health information as identified below to:

(name of recipient facility or doctor)

(address of recipient facility or doctor) _____ (city) _____ (state) _____ (zip)

(facility phone number) _____ (facility fax number)

I, _____ SS# _____ DOB _____
(patient name)
Authorize records to be released from: _____
(name of releasing facility or doctor)

(address of releasing facility or doctor) _____ (city) _____ (state) _____ (zip)

(facility phone number) _____ (facility fax number)
to **Bend Spine and Pain Specialists** to use and/or disclose as identified below to:

I authorize release of my health information to the above listed facility for the following purpose(s), please circle all that apply:

Legal Purposes **Personal Use** **Continuity of Care** **Other** _____

By checking the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

- _____ Please send the entire medical record (all information) to the above named recipient
- _____ All hospital records (including nursing records & progress notes)
- _____ Transcribed hospital reports _____ Clinician office chart notes _____ Billing statements
- _____ Medical records for continuity of care _____ Dental Records _____ Emergency/Urgent care
- _____ Most recent five-year history _____ Laboratory reports _____ Diagnostic imaging reports
- _____ Pathology reports _____ Other _____

The following items must be **INITIALED** to be included in the use or disclosure of other health information:
_____ HIV / AIDS related health information and/or records _____ Mental health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment and/or referral information. Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I may revoke the authorization at any time by giving written notice to Bend Spine and Pain Specialists' Privacy Officer. Unless revoked earlier, this authorization will expire in 180 days from the date of signing or upon (insert date or event of expiration) _____. If action has been taken prior to revocation Bend Spine and Pain Specialists will be unable to take back that action.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.

I further understand that Bend Spine and Pain Specialists does not control the entity receiving this information. If it is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed. The recipient may not have to comply with federal privacy regulations, however, may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

Signature of Individual or Individual's Legal Representative

Date

Printed name of Individual or Legal Representative

Relationship of to Individual