# Cascade Orthopedics & Sports Medicine Center
# Authorization to Use/Disclose Health Information

1715 E. 12th St., The Dalles, OR 97058 - Ph. 541-296-2294 - Fax 541-296-0069

**Revised 7/12/17**

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization*.

**Patient name (Printed)** _____ **DOB** _____ **Phone Number** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**I authorize information to be released:**

**From:** _____ **Individual or Facility** _____ **Phone Number** _____ **Fax**

_____ **Mailing Address** _____ **City** _____ **State** _____ **Zip Code**

**To:** _____ **Individual or Facility** _____ **Phone Number** _____ **Fax**

_____ **Mailing Address** _____ **City** _____ **State** _____ **Zip Code**

**TYPE OF INFORMATION TO BE RELEASED:**

**Body part(s)**_____

_____**Chart Notes**
_____**Physician Notes**
_____**Diagnostic Imaging Reports**
_____**X-Ray Films**
_____**Operative Report**
_____**Worker's Comp Injury Records**
_____**Billing Information**
_____**Other**_____

*Per Oregon statue 192.563 we will charge for records requested for personal use

**The purpose of this request is: (circle all that apply)**

- **Referral of Medical Care (Specialist)**
- **Primary Care Records**
- **Second Opinion**
  - **Appointment Date:** _____
- **Transfer of Care**
- **Legal**
- **Workers Compensation Claim**
- **Billing Purpose**
- **Personal Request**
- **Other** _____

The purpose of this request is at the request of the individual.

**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:**

**(1) Creating health information about you to be disclosed to a third party; or**
**(2) For the purpose of research.**

**You have the right to revoke this Authorization at any time, provided that 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 CASCADE ORTHOPEDICS & SPORTS MEDICINE CENTER at 1715 E. 12th St. The Dalles, OR 97058, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.**
**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.**
**This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.**

**PATIENT AUTHORIZATION TO RELEASE INFORMATION**

**I specifically give authorization to FAX my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information. _____ (initials)**

**Signature of patient or legally responsible person*** _____ **Relationship to Patient** _____ **Date** _____

***To provide the highest level of protection for our medical records, it is our office policy to NOT email medical information.**

*In the event this Authorization is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached. (i.e. Health Care Power of Attorney, or Court appointed Health Care Representative.)

**PLEASE ALLOW 10 WORKING DAYS TO PROCESS REQUEST**

**Patient Delivery Option: Pick Up/ Mail** _____**(Initials)**

**Date Received:** _____/_____**(Initials)** **Date Copied:** _____/_____**(Initials)** **Date Mailed/Faxed:** _____/_____**(Initials)**