PO BOX 648 750 NW 4TH STREET
PRINEVILLE, OR 97754
PHONE: 541-362-8688 FAX: 541-550-7779

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
Name of Patient: DOB:

I hereby Consent and Authorize **Cascade Direct Care** to:

Check at least one:

___Send a copy of my specific health information to person or organization named below.

___Receive a copy of specific health information from person or organization named below.

___Orally exchange specific health information with person or organization named below.

Consisting of (Check all that apply):

___Medical Records ___Appointment Information ___ Billing Information

Other: _____

Specific dates of information, billing, etc: _____

To/From:

Name: _____

Address:_____

City/State/Zip:_____

Phone/Fax Number:_____

For the purpose of: (describe purpose of disclosure):

___Continuing Care

___Other: _____

THE FOLLOWING MUST BE INITIALED IN ORDER FOR IT TO BE INCLUDED IN THE RELEASED RECORDS:

If the information to be disclosed contains any of the types of records or information listed below, the laws relating to this information may apply. I understand that this information will be disclosed <u>if I sign my initials</u> in the applicable space next to the type of information.

_____ HIV/AIDS information **_____ Mental Health information**
_____ Genetic Testing information **_____Drug/alcohol diagnosis, treatment, and referral information**

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and would 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 information and drug/alcohol diagnosis, treatment, or referral information.

Provider Information: You are not required to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization form. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please send a written statement to Paige Ahlberg, Clinic Administrator, at Cascade Direct Care, PO Box 648, Prineville, OR 97754. <u>Verbal revoking of authorizations will not be accepted.</u>

I have read this authorization and I understand it.

_____ _____ Date:_____
Signature of individual or authorized representative

Description of personal representative authority:_____

Unless revoked this authorization will expire in one year from date signed.

Fees for Copies of Records Are as Follows:
1-10 pgs: $1.00/pg
11+ pages: 0.50/pg
Please give us 5 business days from time of request to complete your order.