DESCHUTES RHEUMATOLOGY

2200 NE Neff Rd. Suite #302, Bend, OR 97701
Phone - (541) 388-3978 Fax – 1 (541) 278-8366

AUTHORIZATION TO REQUEST HEALTH INFORMATION

I, _____ /_____/_____
Patient Date of Birth Phone

Authorize **Deschutes Rheumatology, LLC-** to request my health information from:

Name of recipient/Doctor: _____/Phone #:_____

Address of recipient/Doctor: _____/Fax #:_____

By *INITIALING* 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
____Medical records needed for continuity of care
____Most recent five-year history
____Emergency and urgent care records
____Other_____

____Clinician office chart notes
____Dental records
____Laboratory reports
____Pathology reports
____Diagnostic imaging reports
____Billing statements

*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.)

Unless revoked earlier, this consent will expire 6 months from the date of signing or shall remain in effect for a period reasonably needed to complete the request. I understand that I do not have to sign this authorization in order to receive treatment from Deschutes Rheumatology, LLC. I also understand that when my information is used or disclosed pursuant to this authorization; it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to the extent that Deschutes Rheumatology, LLC has acted in reliance upon it. My written revocation must be submitted to the Medical Records Clerk at Deschutes Rheumatology, LLC at 2200 NE Neff Rd. Suite 302, Bend. Or 97701

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)