

DESCHUTES RHEUMATOLOGY

2450 NE MARY ROSE PLACE SUITE 201 BEND, OR 97701
Phone - (541) 388-3978 Fax - (541) 278-8366

AUTHORIZATION TO REQUEST HEALTH INFORMATION

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

Authorize Deschutes Rheumatology, LLC- to release my health information to:

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 _____ Clinician office chart notes
nursing records & progress notes) _____ Dental records

___ Transcribed hospital reports _____ Laboratory reports

___ Medical records needed for continuity of care _____ Pathology reports

___ Most recent five-year history _____ Diagnostic imaging reports

___ Emergency and urgent care records _____ Billing statements

___ 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 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.)