AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Oregon Anesthesiology Group
Phone (503) 299-9906 | Fax (503) 295-2232

Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances where 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 required to make the disclosure.

PATIENT INFORMATION

Patient Last Name:	Patient First Name:	Patient Middle Initial:
Nickname/Maiden Name:	Date of Birth:	Telephone Number: Okay to leave a detailed message? Yes ◯ No ◯
Complete Mailing Address:		

RECORD RECIPIENT INFORMATION

Release my OAG billing records and/or OAG Interventional Pain Clinic medical records to:

Name:	Phone Number:
Complete Mailing Address:	
Fax Number:	Secure Email Address:

REQUIRED: Describe the purpose of the disclosure or indicate it is at the request of the individual:

RECORDS TO BE DISCLOSED

I authorize **Oregon Anesthesiology Group** to use and disclose a copy of the specific health information described below consisting of (please check):

☐ OAG Billing Records ☐ Other Specific Documents:

☐ OAG Interventional Pain Clinic Patients only – Clinical Chart Notes

REQUIRED: Date(s) of service or date range of the records to be disclosed:

INFORMATION ABOUT USE & DISCLOSURE OF HEALTH INFORMATION

If the information to be disclosed contains any of the types of medical records or information listed below, additional laws relating to the use or disclosure of the information may apply. I understand and agree that this information will be disclosed ***if I place my initials in the applicable space provided***.

_____ HIV/AIDS information _____ Genetic testing information

_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

Redisclosure: I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer 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.

Revocation: You may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If you revoke this authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. To revoke this authorization, please send a written statement to the OAG Privacy Officer at Oregon Anesthesiology Group, P.C., 707 SW Washington St., Suite 700, Portland, OR 97205, and state that you are revoking this authorization.

Expiration: Unless revoked earlier, this authorization will expire on the earlier of one (1) year from the

date of signing or on _____ (provide either a date or event).

SIGNATURE OF PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE

I authorize **Oregon Anesthesiology Group** to use and disclose my medical records or billing records as described above.

Signature: _____ Date: _____
(Patient or Patient's Personal Representative)

Printed Name: _____

If you are signing as a Personal Representative of the patient, you must provide a description of your authority to act on behalf of the patient, as well as a copy of official documentation granting this authority:

Source Oregon Revised Statute §192.566 Authorization Form