AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:

Bend Neurological Associates
2349 NE Conners Ave. Bend, Or 97701
Fax: 541-728-0707 Phone: 541-317-0044

RECORDS AND INFORMATION PERTAINING TO:

FULL NAME **DATE OF BIRTH** **PHONE NUMBER**

ADDRESS **CITY** **STATE** **ZIP**

PURPOSE OF RELEASE REQUEST:

___ Changing Providers ___ Legal Reasons __ Doctor Consult/Referral
___ Personal Use ___ Moving/Relocating outside the area

MEDICAL INFORMATION TO BE RELEASE:

____ 2 YEAR HISTORY FOR CONTINUITY OF CARE ____ PATHOLOGY REPORTS _____ ____ LABORATORY REPORTS _____
___ HOSPITAL RECORDS ____ IMAGING/RADIOLOGY REPORTS _____ ____ OTHER: _____
___ BILLING RECORDS ____ RADIOLOGY IMAGING TO DISK_____ _____

THIS REQUEST IS BEING MADE AT THE REQUEST OF THE PATIENT:
BY INITIALZING THE SPACES BELOW, I SPECIFICALLY AUTHORIZE THE DISCLOSURE OF THE FOLLOWING INFORMATION THAT MAY HAVE ADDITIONAL STATE AND FEDERAL PROTECTIONS:

_____MENTAL HEALTH INFORMATION _____DRUG/ALCOHOL INFORMATION
_____HIV/AIDS INFORMATION _____GENETIC INFORMATION

I HEREBY AUTHORIZE: (Medical office ***releasing*** your information)

NAME OF SENDING PERSON/ORGANIZATION FAX NUMBER TELEPHONE NUMBER

ADDRESS CITY STATE ZIP

TO SEND TO: (Medical office ***receiving*** your information)

NAME OF SENDING PERSON/ORGANIZATION FAX NUMBER TELEPHONE NUMBER

ADDRESS CITY STATE ZIP

6. EXPIRATION OF AUTHORIZATION OF RELEASE

This authorization is valid for 365 days from the date of the authorization or until specify date ___/___/___ unless revoked by the patient in writing at an earlier time. I understand that if I am requesting information from Bend Neurological Associates I can revoke this authorization by notifying the Privacy Officer in writing, at 2349 NE Conners ave. Bend, OR 97701. The exception is when the action has already occurred as instructed in this authorization. If signing for a person over 18 years of age, proof of guardianship, healthcare power of attorney, or executor of estate must be provided.

7. DISCLOSURE & AUTHORIZATION SIGNATURE

I understand that I do not have to sign the authorization. My refusal to sign this authorization will not affect my ability to health care services or reimbursement for services except in the circumstance that 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. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Bend Neurological Associates or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions or genetic information.

X x x

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PARTY) RELATIONSHIP TO PATIENT DATE