Bend Spine and Pain Specialists
929 SW Simpson Ave., Suite 250
Bend Oregon 97702
Phone (541)647-1645 Fax (541)647-1648

I, _____ SS#_____ DOB _____
(patient name)

Authorize **Bend Spine and Pain Specialists** to use and/or disclose my health information as identified below to:

_____
(name of recipient facility or doctor)

_____ _____ _____ _____
(address of recipient facility or doctor) (city) (state) (zip)

_____ _____
(facility phone number) (facility fax number)

I, _____ SS#_____ DOB _____
(patient name)

Authorize records to be released from: _____
(name of releasing facility or doctor)

_____ _____ _____ _____
(address of releasing facility or doctor) (city) (state) (zip)

_____ _____
(facility phone number) (facility fax number)

to **Bend Spine and Pain Specialists** to use and/or disclose as identified below to:

I authorize release of my health information to the above listed facility for the following purpose(s), please circle all that apply:

Legal Purposes **Personal Use** **Continuity of Care** **Other** _____

By checking 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 for continuity of care
_____ Most recent five-year history
_____ Pathology reports
_____ Clinician office chart notes
_____ Dental Records
_____ Laboratory reports
_____ Other _____
_____ Billing statements
_____ Emergency/Urgent care
_____ Diagnostic imaging reports

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 may revoke the authorization at any time by giving written notice to Bend Spine and Pain Specialists' Privacy Officer. Unless revoked earlier, this authorization will expire in 180 days from the date of signing or upon (insert date or event of expiration) _____. If action has been taken prior to revocation Bend Spine and Pain Specialists will be unable to take back that action.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.

I further understand that Bend Spine and Pain Specialists does not control the entity receiving this information. If it is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed. The recipient may not have to comply with federal privacy regulations, however, may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

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

_____ _____
Printed name of Individual or Legal Representative Relationship of to Individual