PORTLAND PAIN CARE | Joseph P. Stapleton, MD

Authorization to Use and/or Disclose Health Information

I, (name of patient) ____ (DOB) ______________________________
Authorize (Provider name)
____
To use and/or disclose my health information as identified below to (name and address of recipient)
____
For the following purpose(s): (describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual")
____

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)
_____ Clinician office chart notes
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five-year history
_____ Other
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic 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
_____ * Drugs/alcohol diagnosis, treatment and/or referral information (*Federal regulation requires a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information). ____________
_____ * Psychotherapy notes (if this authorization is for the use and/or disclosure of physiotherapy notes, then it cannot be combined with any other authorization.

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to (identify the person/entity to whom written notice of revocation may be given) ______________________________. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert applicable date or event of expiration ______________________________. 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 copy any information to be used or disclosed under this authorization. I also understand that , if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and not longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

____ ____
Signature of individual or individual's legal representative Date

____ ____
Print name of legal representative (if applicable) Relationship of legal representative to individual

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

Johnson Creek Office
9300 SE 91st Ave, Suite 400
Portland, OR 97086

Hillsboro Office
1849 NW 188th Ave, Suite 201
Hillsboro, OR 97006

Providence Office
5050 NE Hoyt, Suite 204
Portland, OR 97213

Wilsonville Office
8995 Miley Road, Suite 202
Wilsonville, OR 97070

Phone: 503-775-6500 Fax: 503-775-2275