Corvallis Pain Management
PO Box 1166
Corvallis, Or 97339
Phone: 541-286-4742 Fax:541-201-8366

Circle method:
Patient Pickup
Mail
Fax

Authorization for Use or Disclosure of Protected Health Information (PHI)

Please complete entire form. Incomplete authorizations will not be processed and will be returned for completion.

Patient Name ______________________________
Date of Birth ______________
Daytime Phone ______________ Evening Phone ______________
Street Address ______________________________
City, State, Zip Code ______________________________

I authorize *Corvallis Pain Management* ☐ **to disclose PHI to:** ☐ **receive PHI from:**

Name ______________________________
Daytime Phone ______________ Fax ______________
Street Address ______________________________
City, State, Zip Code ______________________________

Information to be released:
From & To Dates ______________
☐ Chart notes ______________
☐ Lab Report(s)______________
☐ Radiology Report(s)______________
☐ Consultation/H & P(s)______________
☐ Emergency/ Urgent Care Records______________
☐ Operative Report(s) ______________
☐ Other______________

I understand that this health information may include HIV/AIDS information and/or information relating to diagnosis or treatment of psychiatric disabilities or substance abuse and/or genetic testing, and that by **initialing** below, I am specifically authorizing the release of information relating to:

____ Drug/alcohol diagnosis, treatment or referral
____ Mental Health
____ HIV/AIDS
____ Genetic Testing

Purpose of Disclosure:
☐ Continuing care ☐ Personal records ☐ Legal ☐ Insurance ☐ On site review ☐ Other ______________

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1. I understand that the information used or disclosed as stated in this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. However, I also understand that federal or state law may restrict re- disclosure of drug/alcohol diagnosis, treatment or referral, HIV/AIDS-related, and psychiatric/mental health information.
2. I understand that Corvallis Pain Management will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.
3. This authorization will expire (insert date or event):__________________, or 6 months from the date of this authorization. A photocopy of this form will be considered as valid as the original.
4. I understand that I may revoke this authorization at any time by notifying the Clinical Staff at either location. This authorization will cease to be effective on the date notified.
5. A copy of this signed form will be provided to the patient or authorized person as requested.

By signing below, I acknowledge that I have read and understand this authorization, and agree to such disclosure.

______________________ ________ OR ______________________ ________
Signature of Patient Date Parent/ Legal Guardian/ Authorized Person Date

______________________ ________ ______________________
Records Received By Date Relationship to Patient