☐ Corvallis Pain Management
545 SW 2nd ST Suite 200
Corvallis, Or 97333
Phone: 541-286-4742 Fax: **541-201-8366**

☐ Corvallis Pain Management-Newport
1010 Bay St
Newport, Or 97365
Phone: 541-265-4473 Fax: 541-265-9156

ID verified by __________
☐ Patient Pickup
☐ Mail / Fax (circle one)

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