Cascade Gastroenterology

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to use and disclose a copy of the specific health information described below
(name of person/entity disclosing information)

regarding: _____ Date of Birth: _____
(name of patient)

to _____
(name and address of recipient)

This information will be used on my behalf for the following purpose(s):

_____
(Describe each purpose of disclosure or indicate that the disclosure is at the request of the individual)

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ All hospital records (including nursing records & progress notes)
_____ Transcribed hospital records
_____ Laboratory reports
_____ Pathology reports
_____ Other: _____

_____ Diagnostic imaging reports
_____ Most recent five year history
_____ Clinician office chart notes
_____ Dental records
_____ Physical therapy records

_____

_____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS related records
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment or referral information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if 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.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Praxis d.b.a. Advanced Specialty Care and state that you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires _____.
(applicable date or event)

By: _____ Date: _____
(individual or personal representative)

Description of personal representative's authority: _____