BEND SURGERY

C • E • N • T • E • R

In for Care • Home for Comfort

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

By signing this form, I, _____, authorize the use and disclosure of health information for _____(patient's name) as described below:

1. Description of information: _____

_____.

2. Person(s) or class of persons authorized to make the use or disclosure of information: _____

_____.

3. Person(s) or class of persons authorized to receive the information: _____

_____.

4. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.

Expiration date (or event) prior to 180 days, if applicable: _____.

5. Description of each purpose of the requested use or disclosure (if substance abuse information is to be disclosed, the purpose of this disclosure must be obtained): _____

_____.

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Bend Surgery Center, Attn: Medical Records Secretary.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by federal Privacy Standards. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment for payment. I may inspect or copy any information used/disclosed under this authorization.

I understand that Bend Surgery Center may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

_____ _____

Signature of Patient or Guardian** Date

_____ _____

Print Name of Patient Date of Birth of Patient

_____

Print Name of Guardian

**If an authorization is signed by an individual's personal representative, the representative's authority is based on: _____

_____(e.g., state law, court order, etc.)

For Bend Surgery Center use only

Information released:

_____

_____

_____

_____

Signature of Employee Releasing Information

_____

Date of Release

_____

Date of patient revocation, if applicable

_____

Employee signature