AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize Pain Management Partners
Dr James Morris , Carolyn Buel ANP
2401 River Rd # 101
Eugene,Or. 97404
(541)344-8469. Fax (541) 687-8631

I authorize _____

to disclose a copy of the medical information for _____
(PATIENT NAME AND DOB)

to _____
(NAME, ADDRESS or FAX NUMBER OF RECIPIENT)

The information will be used on my behalf for the following purpose(s):
_____ Date Range Requesting _____

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

— Chart Notes generated to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all the reasonable charges associated with providing this record.

__ Diagnostic imaging reports
— Billing statements
— Lab/ Pathology Reports
— FMLA/Disability Forms
__ Other_____

Due to large files the records may be burned to a CD

If the information to be provided 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 information
_____ Drug/Alcohol diagnosis, treatment, or referral information
_____ Genetic testing information
_____ Mental Health 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 received health care services or reimbursement for services. The only circumstance when refusal to sign means you will not received 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 PMP , Attention: Medical Records Custodian , and state that you are revoking this authorization.

_____

Unless revoked earlier, this authorization will expire on _____ or 180 days from the date of signing.

SIGNATURE _____ DATE _____