Advanced Pain Management Center
10305 SW Park Way #300 ~ Portland OR 97225
Tel: 503.295.0730 ~ Fax: 503.295-0731

## AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FROM OUTSIDE INDIVIDUALS

Authorization: I authorize ______________________________________________________________
to use and disclose a copy of the health information described below regarding:

Name of patient______________________________________________________________consisting of
**Treatment** (includes activities performed by a physician or other healthcare provider directly delivering care to you, coordinating or managing care provided to you with third parties, and consultations with and between physicians and other healthcare providers including care conferences); **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities including review of healthcare services for medical necessity, justification of charges, precertification and preauthorization of services); **Healthcare operations** (includes the necessary administrative and business functions of your healthcare provider); **Other** (e.g. family/friend, new healthcare provider – include address and phone number below).

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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.

_______ Last 12 months of medical records __________Drug/alcohol diagnosis, treatment or referral information.

_______ Any imaging studies done within the last 18 months ________ Interventional pain management procedures

***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***

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive healthcare service. The only circumstance when refusal to sign means you will not receive healthcare services is if the healthcare 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 above. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please, send a written statement to our office at the above address.

**Signature:** I have read this authorization and understand it. Unless revoked, this authorization expires one year from the date below. ORS 192.521 specifies when a health care provider can charge for copies of medical records <u>and the maximum amount</u> that can be charged. As such, APMC responds only to written requests for medical records. HIPAA provides that a physician may charge a “reasonable, cost-based fee” - see Financial Policy. **I understand that should the decision be made not to take me on as a patient, records received from the above providers will be shredded as no provider-patient relationship was been established. Should I want a copy of those records I understand I will have to contact that provider directly.**

Print Name:_________________________________________ Date:_____________________
(Patient or personal representative)

Signature___________________________________________________________________________