HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Print Name of Patient: _____ DOB: _____

I. My Authorization: I authorize the following using or disclosing party (records needed **FROM**):

☐ Children's Heart Center of Central Oregon, 2041 NE Williamson Ct., Ste A, Bend, OR 97701
☐ Other (include address):

_____

_____

To use or disclose the following health information: (check one)
☐ - All of my health information
☐ - Cardiology records (visit notes, echo reports, EKG, stress test, cardiac catheterization reports, ambulatory monitors, operative summaries, hospitalization discharge summaries)
☐ - My health information covering the period from _____ (date) to _____ (date)
☐- Genetic testing results - **PLEASE INITIAL _____**
☐ - Other: _____

The above party may disclose this health information TO the following recipient:
☐ Children's Heart Center of Central Oregon, 2041 NE Williamson Ct., Ste A, Bend, OR 97701

Fax: 541-507-9181 Phone: 541-639-8333 Email: info@kidsheartco.com

☐ Other (include address and phone):

_____

_____

The purpose of this authorization is:
☐ Continuing care
☐ Other: _____

II. My Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

☐ - Patient is unable to sign because patient is a minor

Signature of Patient/Guardian: _____Date: _____