Aspen Mountain Dermatology
Phone – 541.706.3819 Fax – 541.429.6659
2195 NW Shevlin Park Rd, Suite 100
Bend, OR 97703

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, (patient name)_____SS#_____DOB_____
Requests records from _____(FAX)_____
to use and/or disclose my health information as identified below to **Aspen Mountain Dermatology** for the purpose of continuity of care.

By ***INITIALING*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

____**Please send the entire medical record (*all information*) to Aspen Mountain Dermatology.**

____Clinician office chart notes
____Medical records needed for continuity of care
____Diagnostic imaging reports
____Other_____
____Laboratory reports
____Pathology reports
____Billing statements

*The following items must be ***INITIALED*** to be included in the use or disclosure of other health information:

____*HIV / AIDS related health information and/or records

____*Mental health information and/or records

____*Genetic testing information and/or records

____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke the authorization at any time by giving written notice to *Aspen Mountain Dermatology's* Privacy Officer. Unless revoked earlier, this authorization will expire in 180 days from the date of signing or upon **[insert applicable date or event of expiration]**
_____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual

(A copy of this signed form will be available to the individual and/or the individual's legal representative upon request.)