Hand & Arm Therapy of Central Oregon

2041 NE Williamson Ct
Suite B
Bend, OR 97701
Voice 541-633-7535
Fax 541-706-9036

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient:_____ DOB_____

Address:_____

Home Phone:_____ Cell Phone_____

PATIENT REQUEST FOR MEDICAL RECORD

- ☐ I hereby request to receive a copy of my protected health information
- ☐ I hereby request to receive copies of my billing statements
- ☐ I hereby request an accounting of disclosures of my protected health information made for purposes other than treatment, payment or health care operations (other than insurance, attorney, or physician)

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

- ○ I hereby authorize Hand & Arm Therapy of Central Oregon to use and disclose specific health and medical information about me to the following third party:

Name:_____

Address:_____

Phone/FAX Number:_____

For the following purpose:_____

Information to be disclosed to this third party:

- ☐ My entire medical record
- ☐ Only records of my occupational therapy referral, diagnosis & treatment
- ☐ Only billing statements
- ☐ Only the following specific item(s):_____

If released to a third party, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under applicable federal law. I have read the "Notice of Privacy Practices" for Hand & Arm Therapy of Central Oregon and understand how this clinic uses and discloses information. I also understand I may revoke a request for disclosure <u>in writing</u> at any time, however any previous disclosures made with my permission cannot be taken back. _____ (initial).

Patient Signature:_____ Date:_____

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OR….Patient Representative:_____ Date:_____