Authorization to Use/Disclose Protected Health Information

_____ _____ _____ _____/_____/_____
Patient First Name MI Last Name Date of Birth MM/DD/YYYY

Address: _____ Phone: _____

I HEREBY AUTHORIZE (name of facility which has information)	TO RELEASE INFORMATION/RECORDS TO (name of person or facility to receive information):
Provider Name: _____ Facility Name: _____ Address: _____ _____ Phone: _____Fax:_____	Provider Name: _____ Facility Name: Pacific Sage LLC Mailing Address: 2660 NE Highway 20 Suite 610, #524 _____ Bend, OR 97701 Phone: (541) 762-2727 kFax: (949) 695-4040 (primary Care)

Please specify the health information you authorize to be released:

☐ All Medical Records ☐ Labs/Pathology ☐ Diagnostic Imaging
☐ Immunizations/Vaccinations ☐ Billing/Insurance

Records are needed for continuity of care

If the information to be disclosed contains any of the types of records or information listed below, the laws relating to this information may apply. I understand that this information will be disclosed if I place my initials in the applicable space next to the type of information:

_____HIV/AIDS Information _____Mental Health Information

_____Genetic Testing Information _____Drug/Alcohol (diagnoses, treatment or referral information)

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing inforamtion, and drug/alcohol diagnosis, treatment, or referral information.

Provider information: You do not need to sign this authorizaiton. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are soley for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization 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 authorization form. Any use or disclosure already made with your permission cannot be undone. To revloke, please send a written statement to Clinical Manager, Pacific Sage Primary Care at 2660 NE Highway 20 Suite 610, #524 Bend, OR 97701. Verbal revoking of authorization will not be accepted. **Unless revoked, this authorization will expire one year from signature date. I have read this authorization and I understand it:**

_____ _____
Patient's Signature Date

_____ _____
Authorized Representative Signature Date

_____ _____
Name Relationship