MEDFORD OFFICE:
520 Medical Center Dr, Suite 200, Medford, OR 97504
PHONE 541.930.7222 **FAX** 541.930.7220 **WEB** socardiology.com
GRANTS PASS OFFICE:
520 SW Ramsey Ave, Suite 204, Grants Pass, OR 97527
PHONE 541.930.7223 **FAX** 541.930.7221

SOUTHERN OREGON Cardiology LLC

HIPPA PROTOCOL GIVES HEALTH CARE FACILITY 30 BUSINESS DAYS TO COMPLETE REQUEST FROM DATE RECEIVED

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Birthdate:** _____

From:

Facility Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Fax _____

Physician Name _____

To:

Facility Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Fax _____

Physician Name _____

_____

(SPECIFICALLY DESCRIBE EACH PURPOSE FOR DISCLOSURE)

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.

_____ HIV/AIDS information

_____ Genetic testing information

_____ Mental health information

_____ Sexually transmitted disease information

_____ Alcohol/chemical dependency diagnosis, 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 restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. 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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

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 in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to ***B. Jones*** (contact person) at ***520 Medical Center Dr. , Suite 200, Medford, OR 97504*** (address of person/ entity disclosing information) and state you are revoking this authorization.

SIGNATURE I have read this authorization and I understand it.

By: _____ Date: _____

(PATIENT OR PATIENT REPRESENTATIVE)

Description of personal representative's authority: _____

Unless revoked, this authorization expires: _____

(INSERT EITHER APPLICABLE DATE OR EVENT)