

Dr. Jared R. Nielsen, DC
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PERSON/ENTITY DISCLOSING INFORMATION:

PATIENT IDENTIFICATION:

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PHONE: _____ FAX: _____

PERSON AUTHORIZED TO RECEIVE INFORMATION:

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____

PURPOSE OF REQUEST:

___ TREATMENT OR CONSULTATION ___ AT THE REQUEST OF THE PATIENT ___ BILLING OR
CLAIMS PAYMENT

OTHER: _____

TYPE OF INFORMATION TO BE RELEASED:

___ EMERGENCY ROOM REPORT ___ LABORATORY TEST REPORTS ___ X-RAY REPORTS

___ OPERATIVE REPORT ___ HISTORY & PHYSICAL EXAM ___ X-RAY FILMS/IMAGES

___ DISCHARGE SUMMARY ___ CONSULTATION REPORTS ___ ITEMIZED BILL

OTHER: _____

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 ___ Mental Health Information

___ Genetic testing information ___ Drug/alcohol 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 the

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federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

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I have read and understand that I am signing to release my records.

SIGNATURE: _____ DATE:
