



PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Last Name First Name Date of birth

I authorize Bend Obstetrics & Gynecology to use and/or disclose certain protected health information (PHI) about me to:

Spouse:

Name of individual/entity to receive this information

Parent/Guardian:

Name of individual/entity to receive this information

Other:

Name of individual/entity to receive this information

I do not have to sign this authorization in order to receive treatment from Bend Obstetrics & Gynecology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I decline to authorize any individual/entity to receive my protected health information.

I have the right to revoke this authorization at any time by contacting the Privacy Officer at: 2450 NE Mary Rose Place, Suite 220 Bend OR 97701.

Signed by: Signature of Patient Date Signature of Parent/Guardian Relationship to Patient Print Name of Patient or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION