

Central Oregon Radiology Assoc., P.C.
Cascade Medical Imaging, LLC
Central Oregon Magnetic Resonance Imaging, LLC

AUTHORIZATION to Use or Disclose Health Information
HIGHLIGHTED AREAS ARE REQUIRED

I AUTHORIZE Central Oregon Radiology Assoc., P.C. and/or Central Oregon Magnetic Resonance Imaging, LLC and/or Cascade Medical Imaging, LLC to use and disclose a copy of the specific health and medical information described below for:

(Name of patient)

(Maiden or prior name exams could be filed under)

(Date of birth)

Phone(s) number where you can be reached

Please check type of exam: Mammography Ultrasound MRI CT X-ray

Other: _____

Date of exam(s): _____

Release Films and Reports FROM: (facility name) _____

Facility Address

City

State

Zip

Facility Phone: _____
If Known

Facility FAX: _____
If Known

For The Purpose of: (Check all that apply) Further Medical Care Legal Investigation/Action Personal (at my request)

Comparison

Other: _____

Authorization to request and use information:

Your health care and payment for that health care cannot be conditioned upon receipt of this signed authorization unless your health care or treatment is for the purpose of:

- (1) Creating health information about you to be disclosed to a third party; or
- (2) For the purpose of research.

You have the right to revoke this *authorization* at any time, provided that you do so in writing. If you revoke your *authorization* we will no longer use or disclose information about you for the reasons covered by your written *authorization* but we cannot take back any uses or disclosures already made with your permission. To revoke this *authorization*, please send a written statement to Kris Harvey at 1460 NE Medical Center Drive, Bend, OR 97701 that identifies the date you signed this *authorization*, the recipient of the information identified in this *authorization*, and state that you are revoking this *authorization*.

This *authorization* will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described purpose. **Initial here for permanent records transfer** _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____
Signature of Patient or Patient Representative **Date**

Description of Representative's Authority: _____

**TO E MAIL YOUR
AUTHORIZATION
SEND TO:
medicalrecords@cmillc.org**

Send Images and Reports (on CD as available-DICOM FORMAT ONLY) TO:

Cascade Medical Imaging, LLC

1460 NE Medical Center Dr.

Bend, OR 97701

Medical Records Phone: 541-383-5977 Fax: 541-330-9786

For internal use only: Appointment Date: _____

Called/Faxed: _____

CORA CMI CMIR COMRI

Called/Faxed: _____

Called/Faxed: _____