VASCULAR INTERVENTIONAL SPECIALISTS | CORA

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: _____ **Facility FAX:** _____
If Known **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 a*uthorization 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 a*uthorization,* the recipient of the information identified in this a*uthorization*, and state that you are revoking this *authorization*.

This a*uthorization* 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:** _____

Called/Faxed: _____

☐ **CORA** ☐ **CMI** ☐ **CMIR** ☐ **COMRI** **Called/Faxed:** _____