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ADVANTAGE
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AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____

(Name of Physician/Physican Group)

to use and disclose a copy of the specific health and medical information described below regarding:

Patient Name: _____ DOB: _____

Consisting of: _____

(Describe information to be used/disclosed)

_____

to: _____

(Name, address, phone number, and fax number of recipient or class of recipients)

for the purpose of: _____

(Describe <u>each</u> purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose)

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 Advantage Orthopedics & Sports Medicine Clinic (contact person) at 24076 SE Stark St, Suite 110, Gresham, OR 97030 (address of physician/group practice) 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 reasonable needed to complete the disclosure for the above described purpose.

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

By: _____ Date: _____

(Patient)

- OR -

By: _____ Date: _____

(Patient representative)

Description of Representative's Authority: _____