PARAGON ORTHOPEDIC CENTER
702 SW Ramsey, Suite 112
Grants Pass, OR 97527
(541) 472-0603 Fax (541) 472-0609

AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION I authorize: PARAGON ORTHOPEDIC CENTER

to communicate with the following person(s) regarding my treatment, care and billing matters rendered by this facility:

_____ _____
(NAME OF INDIVIDUAL) (RELATIONSHIP)

_____ _____
(NAME OF INDIVIDUAL) (RELATIONSHIP)

_____ _____
(NAME OF INDIVIDUAL) (RELATIONSHIP)

_____ _____
(NAME OF INDIVIDUAL) (RELATIONSHIP)

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

_____ Alcohol/chemical dependency diagnosis, treatment, or referral information

_____ Sexually transmitted disease 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 federal law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

SIGNATURE I have read this authorization and I understand it.

By: _____ Date: _____
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)