Pediatric Cardiology Center of Oregon
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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize **Pediatric Cardiology Center of Oregon** to use/disclose a copy of the specific health information described below regarding:

Patient Name: _____

Date of Birth: _____

Information to be disclosed: _____

_____

To (Name of recipient, address, email, fax, etc): _____

_____

Reason for disclosure: _____

Special authorization for genetic testing information:
I understand and agree that by placing my initials on the line, I authorize the release and disclosure of genetic testing information.

_____ **Genetic testing information**

This authorization expires one (1) calendar year from the date signed, unless otherwise specified.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when the clinic has already acted in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. Refusal to sign this form will not adversely affect your ability to receive healthcare services or reimbursement for services unless the healthcare services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. To revoke this authorization, send a written statement to the mailing address at the top of this form, attention Privacy Officer.

Once we have disclosed the information at your request, it may be subject to redisclosure and may no longer be protected by federal or state privacy laws.

I have read this authorization and I understand it.

_____

Signature of Patient or Personal Representative **Date**

_____

Printed Name and Relation to Patient (if signed by a representative)