CORA
CENTRAL OREGON RADIOLOGY ASSOCIATES

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

COMRI
CENTRAL OREGON MAGNETIC RESONANCE IMAGING

CMI
CASCADE MEDICAL IMAGING

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:** _____