

Central Oregon Radiology Assoc., P.C.  
Cascade Medical Imaging, LLC  
Central Oregon Magnetic Resonance Imaging, LLC  
1460 NE Medical Center Dr.  
Bend, OR 97701  
541-382-6633

**AUTHORIZATION to Use or Disclose Health Information**

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) (Home Phone number) (Cell Phone Number) (Work Phone Number)

Please check type of exam:  Mammography  Ultrasound  MRI  CT  X-ray  Other

Date of exam(s): \_\_\_\_\_

Send Images and Reports (on CD as available) TO:  
**Cascade Medical Imaging, LLC**  
**62968 Layton Ave, Suite 5**  
**Bend, OR 97701**

**Medical Records Phone: 541-383-5977 Fax: 541-330-9786**

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Release Films and Reports FROM: \_\_\_\_\_  
Facility Name

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

For The Purpose of: \_\_\_\_\_

**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 *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 Kris Harvey at 1460 NE Medical Center Drive, Bend, OR 97701 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 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: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Patient Representative)

Description of Representative's Authority: \_\_\_\_\_

**For internal use only:**