

## AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: (Previous Doctor/Clinic)

\_\_\_\_\_  
\_\_\_\_\_

Phone:

Fax:

To use/disclose medical information to:

**Portland Family Practice**

541 NE 20<sup>th</sup> Ave Suite 210

Portland Oregon 97232

P: (503) 233-6940 F: (503) 236-2676

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Requested time period: Last 2 years (default) or**

Date(s) of Service: from \_\_\_\_\_ to \_\_\_\_\_

Purpose: **Describe** if other than **Continuing Care**

**I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:**

\_\_\_\_ Office Visits \_\_\_\_ Labs \_\_\_\_ Radiology Reports \_\_\_\_ Hospital Records \_\_\_\_ Reports

\_\_\_\_ Other (Describe):

**The following items require a specific authorization and must be INITIALED to be included in the use or disclosure of other medical information.**

\_\_\_\_ HIV/AIDS test or result information and/or records \_\_\_\_ mental health information and/or records

\_\_\_\_ Genetic testing information and/or records

\_\_\_\_ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

*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. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.*

*You do not have to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.*

*I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above my no longer be used or disclosed for purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event)*

\_\_\_\_\_

Date: \_\_\_\_\_

Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Print Patient's Name or Name of Legal Representative and relationship to patient

Patient or Legal Representative: Personal ID Verified.