## AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:
**Portland Family Practice**
541 NE 20th Ave Suite 210
Portland Oregon 97232
P: (503) 233-6940 F: (503) 236-2676

To: ________________________________________
________________________________________
________________________________________
Phone: Fax:

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.***
***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.