

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:

Ph: _____ Fax: _____

To use/disclose medical information to:

Portland Family Practice
541 NE 20th Ave Suite 210
Portland Oregon 97232
Ph: (503) 233-6940 Fax: (503) 236-2676

Name of Patient: _____ Date of Birth: _____

Social Security Number: _____

Date(s) of Service: _____ 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: Dates: _____

____ 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 may 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) _____.

Signature of Patient or Patient's Legal Representative

Date: _____

Print Patient's Name or Name of Legal Representative

Relationship to patient

Patients' or Legal Representative's Personal Identification Verified.