

# AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: Portland Family Practice, Inc.  
541 NE 20<sup>th</sup> Ave Portland Oregon 97232

To use and disclose a copy of the specific health and medical information described below regarding:

\_\_\_\_\_  
(Name of patient)

Consisting of: \_\_\_\_\_

\_\_\_\_\_  
(Describe information to be used/disclosed)

To: \_\_\_\_\_  
(Name and address of recipient or class of recipients)

For the purpose of: \_\_\_\_\_  
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Your health care and payment for health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purposes 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 Bunny MeHarry at Portland Family Practice, Inc. 541 Ne 20<sup>th</sup> Ave, Suite 210, Portland Oregon 97232 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and the date 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.

***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: \_\_\_\_\_

OR

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

(Patient representative)

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