

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: **Portland Family Practice, Inc.**
541 NE 20th Ave Portland Oregon 97232

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

_____ Date of Birth: _____
(Name of patient)

I hereby authorize medical providers and personnel of Portland Family Practice to discuss my protected health information with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ ***Information regarding the patient's diagnosis and treatment for HIV/AIDS***
_____ ***Psychotherapy notes from a Psychiatrist or Psychotherapist***
_____ ***Treatment for alcohol or drug abuse reports***

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose this protected health information expires.

Patient signature: _____ Date: _____

OR

By: _____ Date: _____

(Patient representative)

Description of Representative's Authority: _____

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 Portland Family Practice, Inc. 541 Ne 20th 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 365 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.