AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: (Previous Doctor/Clinic)

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To use/disclose medical information to:

Healthy Living Family Medicine
3605 SE 26th Ave
Portland Oregon 97202
Phone: 971-231-4536
Fax: 1-503-376-3790

Name of Patient: ____ Date of Birth:______________________

Requested time period: O Last 2 years (default) or Date(s) of Service: from _________ to _________

Purpose: O Continuing Care or O Other: ____________________________

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 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 a specific date or event.

____ Date: ______________________
Signature of Patient or Patient's Legal Representative