AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____
(Name of person/entity disclosing information)

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

_____ _____
(Name of individual) *DOB*

You may use or disclose the following health care information (check all that apply):

☐ All Pertinent Records ☐ Consultation ☐ History and Physical ☐ Laboratory ☐ Operative Report	☐ Pathology Report ☐ X-Ray Reports ☐ Billing Record ☐ Other _____ _____

to: _____

to:_____

to:_____

to:_____
(Name and address of recipient or recipients)

Reason(s) for this authorization (check all that apply):

☐ Self ☐ Change of location ☐ Other (specify reason) _____ _____	☐ Continuing medical care ☐ Marketing purposes

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information
___ Mental health information
___ Genetic testing information
___ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION
You do not need 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 services is when 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.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement indicating that you are revoking this authorization to:

Diana Reid, Practice Administrator of Allergy, Asthma and Dermatology Associates
at 12575 NE Marx St., Portland Oregon, 97230
(address of person/entity disclosing information)

SIGNATURE:

I have read this authorization and I understand it. Unless revoked, this authorization expires **1 year from date of signature.**

By: _____Date: _____
(individual or personal representative)

Description of personal representative's authority: _____