



MEDICAL AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

-Completed by Patient, Please Print-

I: I (Patient Name): _____ Date of Birth: _____

authorize the disclosure of my health information as identified below:

From (provider name/address):

To (recipient name /address):

II (a): For the following purpose(s), please check all boxes that apply and include any details:

- Change of Provider** **Continuity of Care** **Relocation**
 Change of Insurance **Provider Not on Panel** **At the Patient's Request**
 Other (for any reason including "Dissatisfaction," please provide feedback on **II (b)** of second page)

III: By checking the boxes below, I specifically authorize the use or disclosure of the following health information and records:

- Entire Medical Record** (all) **Billing Record**
 Medical Records Developed from (start date to end date): _____ to _____
 Other (please specify) _____

IV: ***If the information to be used or disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information will apply. By checking the boxes below, you are agreement with this information being included within this authorization to release information.

- HIV/AIDS Related Health Information/Records**
 Mental Health Information/Records **Genetic Testing Information/Records**
 Drug/Alcohol Diagnosis, Treatment and/or Referral Information (Federal law prohibits the redisclosure of this health information). Federal law requires that a description of the kind of information and how much to be included in this request: _____

V: **Psychotherapy Notes** (if authorization is for the disclosure of psychotherapy notes, it cannot be combined with any other authorization).

*****REQUIRED:** Except to the extent that the action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. Unless revoked earlier, this authorization will terminate on (date or event): _____. I understand I may inspect or copy any information disclosed under this authorization unless otherwise restricted by law. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I understand that the person(s) I am authorizing to use or disclose my information may receive compensation for doing so.

Signature of Individual or Legal Representative

Date

Relationship to Individual



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For any of the sections listed on the previous page, please provide additional information:

II (b): *For the following purpose(s), please check all boxes that apply and include any details:*

Dissatisfaction **Other** (for any reason including "Dissatisfaction," please describe):

Additional comments, suggestions, and recommendations:

Please let us know how we are doing and ways which we can improve your visit and continue to provide your health care. Please call Robert Gessele, Administrator of Fanno Creek Clinic at (503)452-0915 ex. 163 or by E-Mail at rgessele@fannocreek.com with any concerns or recommendations.