Authorization for Use or Disclosure of Protected Health Information

I_____(Patient Name) voluntarily authorize the disclosure of information from my health record.

☐ This is a 2 way release of information from _____ to _____ Between:

Name of Facility/Individual: Dr. Angela Carter	Name of Facility/Individual:
Address: 4115 N Mississippi Ave	Address:
City/State/zip: Portland, OR 97217	City/State/Zip:
Phone: Fax: (503) 459-2584 (503) 719-8244	Phone: Fax:

The Purpose of this Disclosure is:

☐ Continued Medical Care ☐ Attorney ☐ School ☐ Research

☐ Personal Use ☐ Insurance ☐ Disability ☐ Other_____

_____

The information to be disclosed from my health record:

☐ Only information related to:_____

_____

☐ From:_____(date) To:_____(date)

☐ Other:_____

I would like the following Sensitive information disclosed:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-Related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health (other than therapy notes)

☐ Psychotherapy notes ONLY (I am waiving any therapist-patient privilege)

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

Signature:_____ Date:_____

Date of Birth:_____