☐ **Beaverton**
4510 SW Hall Blvd.
Beaverton, OR. 97005
503.644.1171
503.643.7443 fax

☐ **Canby**
1185 S Elm St.
Canby, OR. 97013
503.723.4660
503.266.6649 fax

☐ **North Portland**
6445 N Greeley Ave.
Portland, OR. 97217
503.285.6607
503.285.3195 fax

☐ **Oregon City**
1001 Molalla Ave., Ste 100
Oregon City, OR. 97045
503.656.5273
503.650.4828 fax

☐ **Tigard**
13200 SW Pacific Hwy.
Tigard, OR. 97223
503.598.2000
503.639.0920 fax

Authorization to Share/Disclose Your Protected Health Information to Family Members or a Personal Representative

Patient Name ____

Birthdate ______________________________ Social Security #______________________________

Current Address ____

____

Daytime Phone # ______________________

1) I AUTHORIZE INFORMATION BE RELEASED *TO*:

____
Name and Relationship to Patient

____
Address

____
Address

____
City, State, Zip Phone / Fax #'s

2) I AUTHORIZE INFORMATION BE RELEASED *TO*:

____
Name and Relationship to Patient

____
Address

____
Address

____
City, State, Zip Phone / Fax #'s

Type of Information to be Used/Disclosed

Protected Health Information (PHI)
My protected health information (PHI) includes but is not limited to appointment reminders, medications and education, medical records, hospital or urgent care records, lab results, and treatment plans or options. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

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 only if I place my initials in the applicable space next to the type of information.

______ HIV/AIDS information
Initials

______ Mental health information
Initials

______ Genetic testing information
Initials

______ Drug /Alcohol diagnosis, treatment, or referral information
Initials

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

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 the purposes described in this authorization. Unless revoked earlier, this authorization will expire 24 months from the date of signing or on (insert applicable date or event) ______________________________.

____ ______________________
Signature of Patient Date

____
Print Patient's Name

☐ Patient's Personal Identification Verified ____ Associate Initials

Revised 06.2015