AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:

_____

_____

Ph: _____ Fx: _____

To use/disclose medical information to:

Provider: _____
Hawthorne Wellness Center
3942 SE Hawthorne Blvd.
Portland, Oregon 97214
Ph: (503) 235-5484
Fx: (503) 235-3956

Name of Patient: _____ Date(s) of Service: _____

Date of Birth: _____ SS#: _____

Purpose: Describe if other then Continuing Care _____

I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist. Dates: _____

_____ 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.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services 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. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or legibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

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 (insert applicable date or event) _____.

_____ Date: _____

Signature of Patient or Patient's Legal Representative

_____ _____

Print Patient's Name or Name of Legal Representative Relationship to Patient