**Authorization to Disclose My Health Care Information to**
***Hosseinion Family Medicine, LLC.***

Patient name: _____ Date of birth: _____

Previous name: _____

**I. I Authorize**
**(Prior Doctor's Offices – write their name/clinic here): _____**
**_____**

**To disclose the following:**

- □ All health care information in my medical record
- □ Specific health care information, specify date(s):_____

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply and initial next to all boxes checked):**

- □ HIV (AIDS virus) _____ (initial here)
- □ STDs _____ (initial here)
- □ Mental health _____ (initial here)
- □ Drug or Alcohol use _____ (initial here)

**Please send this health care information to:**
Hosseinion Family Medicine, LLC.
3942 SE Hawthorne Blvd
Portland, OR 97214
Phone 503-234-2070
Fax 1-844-373-1869

The healthcare information requested is to be used by Hosseinion Family Medicine, LLC., for my continued healthcare.

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Hosseinion Family Medicine, LLC. based upon this authorization. You may revoke this authorization by writting a letter to Hosseinion Family Medicine, LLC.

_____

_____

Patient or legally authorized individual signature

Date

_____

_____

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

Last Update:__11__/05____/_2018___ This release expires one year from date of signature.