

Authorization to Disclose Protected Health Information from NW Olive Clinic

Patient Name: _____ Date of Birth: _____ Phone: _____
Address: _____ City _____ State _____ Zip _____

I hereby authorize NW Olive Clinic to disclose my healthcare information to:

Provider / healthcare facility referral _____ other _____

By CHECKING the spaces below, I authorize release of the following records:

Lab / Pathology reports _____ Imaging reports _____

Other, please be specific _____

Clinical Summary _____ includes Problem & Medication Lists _____

The following items must be **INITIALED** to be included in records to be released:

___ HIV/AIDS related record ___ Drug/Alcohol diagnosis, treatment or referral information
___ Genetic testing information ___ Mental Health records

(Federal regulations require a description of how much information and what kind of information is to be disclosed). Describe _____ For the specific purpose of: _____

This authorization will expire in 12 months from the date of signing. As required by the Privacy Regulations, NW Olive Clinic may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office & that revocation will not affect our office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose Protected Patient Health Information.

Signature of Patient or Patient's Authorized Representative
(Relationship) _____ Date _____