WESTOVER HEIGHTS CLINIC · 2330 NW FLANDERS, SUITE 207 · PORTLAND, OR 97210
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AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION TO SELF

PLEASE PRINT ▪ *ONLY FULLY AND PROPERLY COMPLETED FORMS WILL BE PROCESSED* ▪

Patient Name: ______________________________

Patient Address / City / State / Zip: ______________________________

Patient Date of Birth: ____________________ **Telephone:** ____________________

I authorize Westover Heights Clinic to release my Personal Health Information to myself.
Records will ONLY be released using email.

☐ To Be **Emailed To Me** at:

____

This Authorization Form is for the Release of Information to the PATIENT ONLY *(self).*

For release of records to a Medical Provider, please use that Medical Records Release Form.

Information to be disclosed is indicated by the checked box(es) below.
Mark (✓) only those that apply.

- ☐ Medical Summary
- ☐ Laboratory Results
- ☐ Pathology Reports
- ☐ Radiology (Imaging) Results
- ☐ Mammography Results
- ☐ Other – **Please Specify:**

I understand these requested records may contain STD, HIV, substance abuse and/or mental or behavioral health information

The information for which I am authorizing release will **ONLY** be for **PERSONAL USE** ☐ Other **(explain):** ____________

I UNDERSTAND THAT –

- Authorizing the disclosure of the health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department, Westover Heights Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless I specify a shorter period or revoke, this authorization will expire 12 months (one year) from the date of signature below.
- Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- This authorization, unless expressly limited by me in writing, may extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental or behavioral health conditions, as indicated above.

AUTHORIZATION / SIGNATURES

I have read, understand and agree to the terms of this authorization.

Today's Date: ____________________ **Patient Signature:** ______________________________

NOTE: If the patient is 13 years or younger and is not an emancipated minor, the parent or legal guardian must sign. If the patient of any age is unable to sign the authorization for any reason, a legal representative must sign.

Today's Date: ____________________ Guardian/Representative Signature: ______________________________

Relationship to Patient: ____________________ Printed Name: ______________________________

COPY OF FORM GIVEN TO PATIENT ☐ Offered & Given ☐ Copy Declined

Revised August 10, 2012/Reformatted March 2014