WESTOVER HEIGHTS CLINIC · 2330 NW FLANDERS, SUITE 207 · PORTLAND, OR 97210
PHONE: 503-226-6678 ▪ FAX: 503-226-4307

AUTHORIZATION TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION

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

Patient Name: ____________________ **Email:** ____________________

Patient Address / City / State / Zip: ____________________

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

Please Select From ONE of the Following Clinic Locations:

I authorize Westover Heights Clinic TO GIVE INFORMATION TO:	I authorize Westover Heights Clinic TO GIVE INFORMATION TO:
☐ Synergy Women's Health Care 2250 NW Flanders, Suite 205 – Portland, OR 97210 Phone: (503) 227-4050 – Fax: (503) 477-7673	☐ Northwest Dermatology & Research Center 2330 NW Flanders, Suite 201 – Portland, OR 97210 Phone: (503) 223-1933 – Fax: (503) 223-1947

Indicate information to be disclosed by checking box(es) below. ***Mark (✓) only those that apply.***

☐ All Medical Records	☐ Medical Summary	☐ Radiology (Imaging) Results	☐ Other – **Please Specify:**
☐ Progress Notes	☐ Laboratory Results	☐ Mammography Results	
☐ Problem List	☐ Pathology Reports	☐ Operative Results	
☐ Current Medication List	☐ ECG Testing Results		

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

___ HIV/AIDS Information ___ Mental Health ___ Genetic Testing Information ___ Drugs/Alcohol Diagnosis, Treatment or Referrals

The information for which I am authorizing release will be used for:

☐ **Coordination of Care** ☐ **Change of Medical Provider** ☐ **Personal Use** ☐ **Other *(explain)*:** ____________

I UNDERSTAND THAT –

- Authorizing the disclosure of 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.
- 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 information and drug/alcohol diagnosis, treatment or referral information.

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.

Date: ____________________ Guardian/Representative Signature: ____________________

Relationship to Patient: ____________________ Printed Name: ____________________

Revised April 2016