Portland Allergy & Asthma

Ph Happy Valley, OR 971-358-5600 Fax 971-358-5601 || Gresham, OR 971-358-5800 Fax 971-358-5801

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION (Incoming)

Patient Name:_____ DOB: _____

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my medical provider: Name/Address : _____

_____ Fax_____Phone_____
to disclose my health information to Portland Allergy and Asthma, during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released **to** the following office(s):

☐ Portland Allergy & Asthma
2150 NE Division Street Ste 202
Gresham, OR 97030
Phone: 971-358-5800
Fax: 971-358-5801

☐ Portland Allergy & Asthma
9200 SE 91st Ave., Suite 220
Happy Valley, OR 97086
Phone: 971-358-5600
Fax: 971-358-5601

Purpose: I authorize the release of my health information for the following purpose:

☐ Personal Use
☐ Changing Doctors
☐ Moving/Relocating
☐ Allergy shots to be given by a different provider
☐ Continued Care
☐ Other: _____

Information to be disclosed: I authorize the release of the following health information: (check all that apply)

☐ My entire health record and health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
☐ My allergy shot prescription.
☐ My allergy shot record.

- o My allergy extract vials. ALL EXTRACTS MUST BE SENT TO VIA FED EX, UPS OR HAND CARRIED REQUIRING A SIGNATURE, WE WILL NOT ACCEPT VIALS VIA USPS.

Term: I understand that this Authorization will remain in effect:

- o From the date of this Authorization until the_____day of_____,20_____.
- o Until the Provider fulfills this request.
- o Until the following the event occurs:_____.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____

Patient/Guardian Signature Date

If individual is unable to sign this Authorization or is under the age of 18, please complete the information below:

_____ _____ _____

Name of Guardian/ Representative Legal Relationship Date