Authorization to Disclose Protected Health Information To
Peach Skin North Portland Healthcare

Patient Name**:** _____

Date of Birth: ____/____/____ Phone: _____

Address: _____
Mailing address *City* *State* *Zip*

Name: _____ Phone: _____
Outside Provider / healthcare facility name
Fax: _____

Address: _____
Mailing address *City* *State* *Zip*

I authorize disclosure of my healthcare information To: Peach Skin North Portland Healthcare, at the following location: 3537 N. Williams Ave, Portland OR 97227

I authorize release of the following records (check all that apply):

- ☐ Lab / Pathology reports – past 6 months
- ☐ Lab / Pathology reports – past 1 year
- ☐ Imaging reports – past 6 months
- ☐ Clinical Summary – includes Problem & Medication Lists
- ☐ Imaging reports – past 1 year
- ☐ Clinical records from ____/____/____ to ____/____/____
- ☐ Other – *Please be specific* _____

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
____Mental Health records
____Genetic testing information

Describe _____
(Federal regulations require a description of how much information and what kind of information is to be disclosed)

For the specific purpose of: _____

This authorization will expire 180 days from the date of signing.
As required by the Privacy Regulations, Peach Skin N. Portland Healthcare 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 and that revocation will not affect this 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 a 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*
Minors: a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).