AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Name and Address of Health Care Provider

_____ Scott N. Losk, Ph.D. _____ James H. Bergthold, M.D. _____ MaryAnn Conrad, M.D.

_____ Mary Horton A.N.P_____ Beal G. Essink, M.D.

2701 NW Vaughn St Suite 350 Portland OR 97210 Phone: 503-279-8252 Fax: 503-279-8926

To Use/Disclose/Exchange Medical Information with: Clinic/Doctor: _____

Clinic/Dr. Address: _____City: _____ State: _____

Clinic/Dr. Phone: _____ Clinic/Dr. Fax: _____

Name of Patient: _____ DOB: _____

The purpose or need for the exchange and disclosure of this information is to:

____ Facilitate treatment;
____ Summarize treatment and/or;
____ Other _____

By initialing the spaces below, I specifically authorize the use, disclosure, and/or exchange of the following medical information, and/or medical records, if such information and/or records exist:

____Problem List

____Current Medication List

____ Admission and Discharge Summary ONLY

Other: _____

*The following items must be initialed to be included in the use, disclosure, and/or exchange of other medical information:

_____*HIV/AIDS test or result information and/or records
_____*Mental Health information and/or records
_____*Genetic testing information and/or records
_____*Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure if HIV/AIDS test or result information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that the person or entity I am authorizing to use/disclose/exchange information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may not longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert date or event) _____

_____ _____
Signature of patient or patient's legal representative Date

_____ _____
Print patient's name or name of legal representative Relationship to patient