AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION I authorize:_____
(NAME OF DOCTOR/CLINIC DISCLOSING INFORMATION)

to use and disclose the specific health information described below regarding:

_____
(PATIENT NAME) (DATE OF BIRTH)

consisting of:

_____ Physician notes and records (limited to 2 years of information)

_____ Lab test results

_____ Imaging reports

_____ Other information: _____

to: **Happy Doc Family Medicine**

4744 Liberty Rd S, Suite 120, Salem, OR 97302. Ph: 971-599-1002, **F: 503-967-6107 (preferred)**

for the purpose of: continued medical care

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 information

_____ Genetic testing information

_____ Alcohol/Chemical Dependency diagnosis, treatment, or referral information

I understand that 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 testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Dr. Lara Knudsen at 4744 Liberty Rd S, Suite 120, Salem, OR 97302 and state you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires in 90 days.

_____

Signature of patient (or legally responsible person)-state relationship to patient Date

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