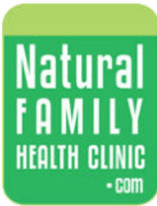

Natural Family Health Clinic, LLC
14900 SW Barrows Rd, Bldg B, Suite 201, Beaverton, OR, 97007
Phone: 503-246-2995 Fax: 503-379-0391

Authorization to Disclose Protected Health Information

Patient name:____ DOB: ____/____/____

Address: ____Phone: __________________

☐ **I would like my information disclosed to Natural Family Health Clinic**

☐ **I would like my information disclosed from Natural Family Health Clinic**

To (Physician/Office) : ____

Address: ____

Phone: ___________________________ Fax: ___________________________

I hereby authorize Natural Family Health Clinic to share my health information as specified above.

By INITIALING the spaces below, I authorize release of the following records:

_____ Entire Medical Record (For the past two years)
_____ Laboratory Report (specify): ____
_____ Operative Report (specify): ____
_____ Pathology Report (specify): ____
_____ Radiology Report (specify): ____
_____ Other (specify): ____

The following line must be initialed to have information included in the health record:
_____ Information related to HIV/AIDS; Drug/Alcohol Diagnosis, Treatment or Referral information; Genetic Testing Information; Mental Health Record/Psychotherapy Notes.

Federal Regulation requires a description of how much and what kind of information is the be disclosed. Please describe the information you would like disclosed, as well as any information you would like omitted from this release of records. This release will be active for one year from the date of signature, or until _______________.
(Specify Date)

Describe: ____

The Natural Family Health Clinic, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your specific authorization. I understand that Natural Family Health Clinic is not responsible for securing your information on the receiving end and that the information disclosed above may be re-disclosed to additional parties by the recipients and may no longer be protected for reasons beyond our control.

I understand that 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 the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. 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.

____ ____________________
Signature of Patient **Date**

____ ____________________
Signature of Authorized Representative (If relevant) **Date**

Relationship to patient: ___________________________________