SUNSET MEDICAL PRACTICE AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Sunset Medical Practice 12400 NW Cornell Road, Portland OR 97229 Ph: 503 626-0939 FAX: 503 626-6161

Release PHI to: _____

OR Obtain PHI from: _____

Address: _____

Phone: _____ **Fax:** _____

Patient Name: _____ **DOB:** _____

Consisting of:

☐ **Hospital Records** ☐ **Medical Records Needed for Continuity of Care** ☐ **Most Recent ___ Year History**

☐ **Laboratory Reports** ☐ **Pathology Report** ☐ **Diagnostic imaging reports** ☐ **Physical Therapy Records**

☐ **Emergency and Urgent Care Records** ☐ **Billing Statements** ☐ **Chart Notes/Progress Sheets**

☐ **This authorization is limited to the following treatment** _____

☐ **This authorization is limited to the following time period** _____

For the purpose of: ☐ **Transfer of Primary Care** **OR** ☐ **other:** _____

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 information**
____ Drug/alcohol diagnosis, treatment or referral information

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

PROVIDER 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 are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

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 Sunset Medical Practice, 12400 NW Cornell Road, Portland OR 97229 and state that you are revoking this authorization

I have read this authorization and understand it.

Signature of Patient: _____ **Date:** _____

By: _____ **Relation to Patient:** _____

Unless revoked this authorization expires: _____