SUNSET
medical practice group, p.c.

SUNSET MEDICAL PRACTICE AUTHORIZATION
TO *DISCUSS/DISCLOSE* PROTECTED HEALTH INFORMATION

I authorize **Sunset Medical Practice** to discuss/disclose the specific health information described below regarding (patient name)

_____DOB_____

Consisting of

_____

_____

(describe information to be discussed/disclosed)

To/With:

_____relationship _____

_____relationship_____

_____relationship_____

For the purpose of_____

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 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.

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. Fax 503-626-6161 Phone 503-626-0939

I have read this authorization and understand it.

Signature: _____ **Date:** _____

By: _____ Relation to Patient: _____

Unless revoked this authorization expires: _____