



**Baker Allergy, Asthma & Dermatology**  
**Authorization to Use or Disclose Protected Health Information (PHI)**

*I authorize Baker Allergy, Asthma and Dermatology to disclose the following information from the health records of:*

The individual for whom this authorization is being requested. Please complete the following:			
Name _____		Chart # _____	
Address _____		City _____	State _____ Zip _____
Area Code & Telephone Number _____		Date of Birth _____	
<i>Dates of Service: From</i> _____		<i>To</i> _____	
Information Requested			
<input type="checkbox"/> All Pertinent Records <input type="checkbox"/> Assessments <input type="checkbox"/> Consultation <input type="checkbox"/> History & Physical <input type="checkbox"/> Operative Report		<input type="checkbox"/> Pathology Report <input type="checkbox"/> X-Ray Films <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Billing Record <input type="checkbox"/> Other _____	
Purpose:			
<input type="checkbox"/> Self <input type="checkbox"/> Other: (specify reason) _____		<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request	
Information to be Given to:			
Company, Person, Facility _____		Phone Number _____	
Address _____		City _____	State _____ Zip Code _____

- I understand that I may refuse to sign this authorization form. Your health care and payment for that health care cannot be conditioned upon receipt of this signed authorization
- I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Baker Allergy, Asthma & Dermatology Notice of Privacy Practices explains the process for revocation, which includes a request in writing to 3975 SW Mercantile Drive, Suite 158/165 Lake Oswego, OR 97035.
- Unless I revoke this authorization earlier, **it will expire 6 months from the date signed or as specified:** Date: \_\_\_\_\_.
- I understand that if this information is disclosed to a third party, the information may no longer be protected by the state and federal regulations and may be re-disclosed by the person or organization that receives the information.
- I release Baker Allergy, Asthma and Dermatology and its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature of the Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the Legal Representative

\_\_\_\_\_  
Relationship to Patient