Baker Allergy, Asthma and Dermatology

9495 SW Locust Street, Suite A
Portland, OR 97223

Patient Information

_____ _____
Name Date of Birth

_____
Address

_____
City State Zip

Communication Preferences

_____ □ Consent to leave detailed voice message
Preferred contact phone number □ Consent to text

HIPAA Privacy Authorization

I understand that Baker Allergy Asthma and Dermatology may still use and disclose protected health information as indicated in the Notice of Privacy Practices.
Would you like to give someone else access to your medical records?
□ Yes, I would like to give access to the following friends, family, or caregivers: □ No

_____ Full Name (First and Last) or Entity _____ Address _____ Relationship	_____ Phone	Authorized to Disclose: □ Access to medical information (i.e., appointments, diagnoses, treatment plans, chart notes, test results) □ Access to billing information (i.e., balances, payment plans, claims processing, receipts)
_____ Full Name (First and Last) or Entity _____ Address _____ Relationship	_____ Phone	Authorized to Disclose: □ Access to medical information (i.e., appointments, diagnoses, treatment plans, chart notes, test results) □ Access to billing information (i.e., balances, payment plans, claims processing, receipts)

- This Authorization is being granted at the request of the individual.
- Unless otherwise revoked, this Authorization expires 12 months after the date of signing this form.
- I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.
- I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I release Baker Allergy, Asthma & Dermatology, their 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