BAKER
ALLERGY · ASTHMA
DERMATOLOGY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

RECORDS RELEASE

RELEASE MEDICAL RECORDS TO / FROM (Please Circle):	RELEASE MEDICAL RECORDS TO / FROM (Please Circle):
Baker Allergy, Asthma & Dermatology Name	_____ Name
9495 SW Locust Street, Suite A Street Address	_____ Street Address
Portland, OR 97223 City, State, Zip Code	_____ City, State, Zip Code
503-636-9011 503-636-3952 Phone Number Fax	_____ Phone Number Fax

PATIENT INFORMATION

_____ _____ _____
Patient Name Date of Birth Phone Number

_____ _____ _____ _____
Address City State Zip

_____ _____
Patient Legal Guardian (If Applicable) Relationship to Patient

INFORMATION REQUESTED

□ All Pertinent Records □ X-Ray Reports □ Labs □ Consultation □ History & Physical □ Last 2 Years Complete Records

□ Pathology Reports □ Assessments/Chart Notes □ Billing Record □ Operative Report □ Other (specify):_____

PURPOSE

□ Self □ Continuing Medical Care □ Attorney Request □ Other: (specify):_____

DISCLOSURE OF SPECIALLY PROTECTED INFORMATION

If the information to be disclosed contains any of the types of records/information listed below, additional laws relating to the use and disclosure of the information may apply. This information *will be disclosed* if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Genetic testing information
_____ Mental health information
_____ Drug/alcohol diagnosis, treatment, or referral information

- I understand that I may refuse to sign this authorization form. My health care and payment for that health care will not 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: Attn: Records, Baker Allergy, Asthma & Dermatology, 9495 SW Locust Street, Suite A, Portland, Oregon 97223.
- 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 redisclosed by the person or organization that receives the information. However, 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.
- 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.
- Unless I revoke this authorization earlier, **it will expire 6 months from the date signed or as specified:** _____
  Date

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Legal Representative Relationship to Patient Date