



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

RECORDS RELEASE			
<p style="text-align: center;"><u>RELEASE MEDICAL RECORDS</u> <u>TO / FROM (Please Circle):</u></p> <p>Baker Allergy, Asthma & Dermatology Name</p> <p>9495 SW Locust Street, Suite A Street Address</p> <p>Portland, OR 97223 City, State, Zip Code</p> <p>503-636-9011 503-636-3952 Phone Number Fax</p>	<p style="text-align: center;"><u>RELEASE MEDICAL RECORDS</u> <u>TO / FROM (Please Circle):</u></p> <p>_____ Name</p> <p>_____ Street Address</p> <p>_____ City, State, Zip Code</p> <p>_____ Phone Number Fax</p>		
PATIENT INFORMATION			
<p>_____ Patient Name</p> <p>_____ Address</p> <p>_____ Patient Legal Guardian (If Applicable)</p>	<p>_____ Date of Birth</p> <p>_____ City</p> <p>_____ Relationship to Patient</p>	<p>_____ Phone Number</p> <p>_____ State Zip</p>	
INFORMATION REQUESTED			
<p><input type="checkbox"/> All Pertinent Records <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Consultation <input type="checkbox"/> History & Physical <input type="checkbox"/> Last 2 Years Complete Records</p> <p><input type="checkbox"/> Pathology Reports <input type="checkbox"/> Assessments/Chart Notes <input type="checkbox"/> Billing Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Other (specify): _____</p>			
PURPOSE			
<p><input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request <input type="checkbox"/> Other: (specify reason): _____</p>			

- 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: Baker Allergy, Asthma & Dermatology, 9495 SW Locust Street, Suite A, Portland, Oregon 97223.
- Unless I revoke this authorization earlier, **it will expire 12 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 & 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 Patient

Date

Signature of Legal Representative

Relationship to Patient

Date