

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION
5909 S.E. Division St., Portland, OR 97206 • Phone (503) 234-1531 Fax (503) 234-2367

_____**Joan Takacs, D.O.,** _____**John Takacs, D.O.,** _____**Debra Glasser, M.D.,**
_____**Janel Guyette, M.D.,** _____**Susan Schmitt, M.D., GCFP**

I authorize the following health care provider/hospital listed below to use and disclose a copy of the specific health and medical information described below regarding: _____

From: _____ (Name of patient) To: _____ (Patient's date of birth)

The information will be used on my behalf for the following purpose(s):

_____ Continuity of Care _____ Transferring Physician _____ Billing _____ Other (please describe)

By initialing the spaces below, I specifically authorize the release of the following information, if such records exist:

_____ Medical records and office chart notes for continuity of care _____ Lab reports / Pathology reports
_____ Diagnostic imaging reports (x-ray, MRI, CT scan, Ultrasound) _____ Billing statements
_____ Emergency, urgency care records, hospital records
_____ Other _____
_____ * **HIV/AIDS – RELATED RECORDS**
_____ * **MENTAL HEALTH INFORMATION**
_____ * **GENETIC TESTING INFORMATION**

ALL ITEMS THAT HAVE AN ASTERISKS NEXT TO THEM (*) MUST BE INITIALED TO BE INCLUDED WITH OTHER DOCUMENTS.

****DRUG/ALCOHOL DIAGNOSIS, TREATMENT OR REFERRAL INFORMATION, FEDERAL REGULATION, 42 CFR PART 2, REQUIRES A DESCRIPTION OF HOW MUCH AND WHAT KIND OF INFORMATION IS TO BE DISCLOSED.**

_____ **** This authorization is limited to the following treatment:** _____
_____ **** This authorization is limited to the following time period:** _____
_____ **** This authorization is limited to a worker's compensation claim for injuries of** _____
Date of injury _____

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

1. Creating health information about you to be disclosed to a third party; or
2. For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Medical Records Department at 5909 S.E. Division ST., Portland, OR 97206, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that your are "revoking this Authorization".

This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. I also understand this record may be voluminous and agree to pay all reasonable charges associated with providing this record. \$3.50 for the first page and \$0.50 for each additional page.

(Patient or Patient's representative)

(Date)

Description of Representative's Authority: _____