**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Patient's Full Name: _____ Date of Birth:_____

By signing this form, I authorize_____

Phone number:_____Fax number_____

to release confidential health information about me by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

**The information you may release subject to this signed release form is as follows:**

____All Medical Records ____Imaging ____Problem List

____Progress Notes ____Medication Records ____Operative Reports

Release my protected health information to the following physician/person/facility/entity and/or those directly associated with my medical care:

| | |
|---|---|
| Name: | Good Health Physical Therapy |
| Phone: | 503-292-5882 |
| Fax: | 503-292-5899 |
| Address: | 4475 SW Scholls Ferry Rd, Suite 258 |
| City, State, Zip: | Portland, OR 97225 |

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

**_____Genetic testing information _____HIV/AIDS information _____Mental Health**

**_____Drugs/alcohol diagnosis, treatment, or referral information**

You have the right to revoke this Authorization at any time, provided 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. Still, we cannot take back any disclosures already made with your permission. To evoke the release of your records with this authorization, please send a written statement to our clinic at 4475 SW Scholls Ferry Rd, Suite 258 Portland, OR 97225 that identifies the date you signed the authorization, the recipient of the information in the authorization and state you are revoking this authorization. This authorization will expire one year from when it was signed. I understand that uses and disclosures already made based on my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

_____ _____

Patients Signature / Or Representative for Patient If Representative Relationship to Patient

_____

Date