

Scholls Family Care

P.O. Box 86272

Portland, OR 97286-0272

Last Name	First Name	MI	Date of Birth
Address			City, State and Zip Code
Telephone			

Release of Records AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I request and authorize Scholls Family Care to release my medical records as indicated below:

- To send records from Scholls Family Care to:

Facility or Clinic Name:		Facility or Clinic Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:

This request and authorization applies to:

- All healthcare information (**Indicate HIV/AIDS, Mental Health and Drug/Alcohol below**)
- Healthcare information relating to the following: _____
- Other: _____

I understand and agree that the information to be disclosed may include the following, which are either protected under Oregon or other federal law: HIV/AIDS information, mental health information, genetic testing information, or alcohol/chemical dependency diagnosis, treatment or referral information. I understand and agree that protected information will be **disclosed as indicated below**:

I do	I do not	Authorize the release of information related to:
<input type="checkbox"/>	<input type="checkbox"/>	HIV Infection or AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Information/Records (Psychiatric and/or Psychological)
<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol diagnosis, treatment and/or referral information

Time limit and right to revoke: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 14795 SW Murray Scholls Dr Ste 121, Beaverton, OR 97007. Unless revoked, this authorization will expire on the following date or event _____, **or one year from date of signature**, unless otherwise specified.

Re-disclosure

I understand that once information is released to the above person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party. I can inspect or copy the protected health information to be used or disclosed.

By signing below I have read this authorization and I understand it.

I authorize Scholls Family Care to use and disclose the protected health information as specified above.

Signature of Patient/Personal Representative Date Printed Name of Patient/Personal Representative