Natural Family Health Clinic, LLC
14900 SW Barrows Rd, Bldg B, Suite 201, Beaverton, OR, 97007
Phone: 503-246-2995 Fax: 503-246-1478

Authorization to Disclose Protected Health Information

Patient name:_____ **DOB:** ____/____/____

Address: _____**Phone:** _____

CHECK RELEVANT BOX:

☐ **I authorize disclosure of my information TO Natural Family Health Clinic**

☐ **I authorize release of my information FROM Natural Family Health Clinic**

SEND TO:

(Physician/Office/Individual) : _____
Address: _____
Phone: _____ **Fax:** _____

I hereby authorize Natural Family Health Clinic to share my health information as specified above.

DESCRIPTION OF INFORMATION TO DISCLOSE

_____ Entire Medical Record (For the past two years)
_____ Laboratory Reports (All Labs or Specify): _____
_____ Operative, Pathology, and Radiology Reports (Specify):_____
_____ Other (specify): _____

The following lines ***must*** be initialed to have information included in the health record:
_____ Information related to HIV/AIDS
_____ Drug/Alcohol Diagnosis, Treatment or Referral information
_____ Genetic Testing Information (example: MTHFR genotyping)
_____ Mental Health Record/Psychotherapy Notes.

This release will be active for one year from the date of signature, or until _____.
(Specify Date)

The Natural Family Health Clinic, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your specific authorization. I understand that Natural Family Health Clinic is not responsible for securing your information on the receiving end and that the information disclosed above may be re-disclosed to additional parties by the recipients and may no longer be protected for reasons beyond our control.

I understand that I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. I also understand that if I do not sign this document it will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Representative (If relevant) **Date**

Relationship to patient: _____