AUTHORIZATION TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law.

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Initial
Nickname/Maiden Name	Birthdate	Telephone: Okay to leave detailed message? **Yes** **No**
Patient's Mailing Address		

Healthcare Provider to **Release** Information

Name		
Address		
City	State	Zip Code
Phone	Fax	

Person or Facility to **Receive** Information

Name Pearl Health Center		
Address 721 NW 9th Ave., Suite 100A		
City Portland	State OR	Zip Code 97209
Phone 503-525-0090	Fax 971-244-0219	

Purpose of Release: _____

If such information exists, I authorize the disclosure of ☐ Entire Medical Record or ☐ the following specific documents, dates of service, and/or information about the following injury/illness/disease:_____

The following items **MUST BE INITIALED** to be release:

_____ HIV- Positive test results and HIV diagnosis

_____ Genetic Testing Information and/or Records

_____ Drug/Alcohol Diagnosis, Treatment, or Referral Information

_____ Mental Health Information

_____ Sexually Transmitted Diseases

_____ Continuity of Care

Federal or State law may restrict re-disclosure of HIV-positive test results and HIV Diagnosis, other sexually transmitted disease information, specifically protected mental health information, genetic test information, and drug/alcohol diagnosis, treatment, or referral information.

By signing below I agree to release the aforementioned health information and I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I may revoke this authorization in writing at any time, to the extent that action has been taken in reliance upon this authorization.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on:_____. (do not date todays date)

_____ _____

Signature of Patient or Patient's Legal Representative Date