Authorization to Use/Disclose Health Information

Maple Street Clinic, P.C.
Family Medicine
1825 Maple Street, Forest Grove, OR 97116
Phone (503) 357-2136 Fax (503) 359-5479

Patient Name	**Date of Birth**

Request records FROM::	**Send records TO:**
Name of Provider/Organization **Maple Street Clinic PC**	Name of Provider/Organization
Address **1825 Maple St**	Address
City, State, Zip **Forest Grove OR 97116**	City, State, Zip
Phone **503 357-2136**	Phone
Fax **503 359-5479**	Fax

Health care information to be used or disclosed consists of the last 2 years of medical records for continuity of care.
If specific records are needed for different purposes, please list.

Other _____ Time period _____

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.

_____ HIV/AIDS information _____ Mental health information
_____ Genetic testing information _____ Drug / alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You are not required to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you 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.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Maple Street Clinic, P.C. and state that you are revoking this authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have read and understand the above information and have asked questions for verification where needed.

Signature of Patient	Date	Parent/guardian of minor, or personal representative	Date