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

*This authorization must be written, dated and signed by the patient of by a person authorized by law to give authorization.*

I authorize\_\_Heather Lokteff, LPC 4800 SW Meadows, Suite 300, Lake Oswego, OR 97035\_\_\_\_\_\_\_\_\_\_\_503-806-2012\_\_\_\_\_\_\_\_\_

(Name of Facility or Provider) (Address) (Phone Number)

to use and disclose a copy of the specific health information described below regarding:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient’s complete name and date of birth)

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(Name of Health Care Facility and Provider) (Address) (Phone Number)

For the purpose of: (Describe each purpose of disclosure)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***By initialing the space below, I specifically authorize the release of the following medical records, if such records exist:***

\_\_\_Most recent 3 years of medical records \_\_\_Laboratory Reports \_\_\_Billing statements

\_\_\_Clinician chart notes \_\_\_Diagnostic imaging reports \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_All hospital records \_\_\_Dental records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Transcribed hospital reports \_\_\_Entire medical records needed for continuity of care

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to exchange verbal or written protected health information

(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 highly confidential information may apply. I understand and agree that this highly confidential information will be disclosed if I place my initials in the applicable space.)

***Please initial space below when applicable:***

\_\_\_HIV/AIDS related records \_\_\_Mental health information \_\_\_Drug/alcohol diagnosis, treatment

\_\_\_Genetic testing information \_\_\_Psychotherapy notes or referral information

Indicate any limitations of disclosure below:

\_\_\_This authorization is limited to the following treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_This authorization is limited to the following time period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_This authorization is limited until the request is fulfilled.

I understand that the information used or disclosed may be subject to re-disclosure, except for highly confidential information.

(You do not need to sign this authorization. Refusal to sign the authorization will not affect your ability to receive health care services or reimbursement for services. Refusal to sign means you will not receive health care services if they are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure. This authorization may be revoked in writing at any time. To revoke this authorization, please send a written statement to Heather Lokteff, LPC. 4800 SW Meadows Rd. Suite 300 Lake Oswego, OR 97035. Please state you are revoking this authorization.)

I have read this authorization and I understand it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Patient representative if applicable