Authorization to Disclose Protected Health Information to Everyday Wellness Clinic LLC

Patient:________________________________ Address:____

Phone: ________-_______________________ Date of Birth _______/_______/__________

As required by the Privacy Regulations Everyday Wellness Clinic may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize: ____**Phone** _______________________

Address: ____

Street number ***City*** ***State*** ***Zip***

to disclose my Patient Health Information to **Everyday Wellness Clinic LLC 503.222.1315**

☐ Dr. Laura Torgerson

Mail to: Everyday Wellness Clinic LLC
1033 SW Yamhill St
#300 Portland Oregon 97205

*****<u>ATTN</u>: *<u>MAIL if MORE than 15 pages</u>******

Fax to: 503-222-1317

*By **<u>initialing</u>** the spaces below, I authorize the release of the following records, if such records exist:*

___ Entire medical record ___ Progress notes ___ Laboratory
___ Pathology reports ___ EKG ___ X-ray, CT, MRI, Imaging
___ Operative report ___ Other (specific)____

The following items *must* be **initialed** to be included in other documents:
___ HIV/AIDS related records ___ Mental Health records
___ Drug/Alcohol diagnosis, treatment or referral information ___ Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed).
Describe____

For the specific purpose of (describe in detail):

____

This authorization will expire 180 days from the date of signing.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand 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. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. 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 whether or not I provide authorization to use or disclose protected patient health information.

____ ______/______/_____
Signature of Patient or Patient's Authorized Representative (relationship) *Date*