1471 Pearl Street, Suite 2, Eugene, OR 97401 Phone: 541-338-9494 Fax: 541-338-8496

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FORM

Patient Name: ____
Date of Birth: ____________________________ Home Phone: ________________________

Purpose of Release Request:
□ Doctor Consultation / Referral □ Self-Use □ Other (please specify) _____________________

I authorize the information designated above to be released from (please be complete and specific):
Name of Facility and Address: ____
Name of Doctor or Department: ______________________________ Date(s) of Service: _______________________
Information requested: □ Physician notes □ Lab / Imaging results □ Other (please specify) ________________

IF MORE THAN 10 PAGES—PLEASE MAIL!!!!

I authorize the information above to be released to:
Name and Address of Facility: **Clinic of Natural Medicine. 1471 Pearl St, Suite 2. Eugene, OR 97401**
Name of Doctor (circle one): **Dr. Michelle Niesley, Dr. Stacy Dunn, Dr. Teresa Silliman**

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. 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 information.

Disclosure and Authorization Signature (*required*):
I understand I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive 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 purposes of providing health information to someone else, and the authorization is necessary to make that disclosure.

I understand I may revoke this authorization in writing at any time. If I revoke my 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 your provider at the Clinic of Natural Medicine at the address noted above. I have read this authorization and I understand it. Unless revoked, this authorization expires two years after signing below.

By: ____ **Date:** _______________________
(Patient or personal representative)

Description of personal representative's authority: ____