Patient Authorization to Release Health Information

Patient name _____ Date of Birth _____ Telephone Number _____

I authorize Northwest Health & Healing to do the following:

☐ Provide information to the Facility/Person listed below. ☐ Receive information from the Facility/person Listed below.

Facility/Person _____ Phone Number _____

Street Address _____ City/State/Zip _____

The information will be used on my behalf for alternative healthcare.

Information to Be Disclosed:

- ☐ Entire Chart
- ☐ Most Recent 5 year history
- ☐ History & Physical
- ☐ Medications/Therapy
- ☐ Lab/Pathology/ECG Reports
- ☐ Imaging Reports
- ☐ All Clinician(s) Chart Notes
- ☐ Immunizations
- ☐ Problem List
- ☐ Operative Reports
- ☐ Other Records as Specified: _____

☐ Specific Dates of treatment: _____

By initialing in the spaces below, I authorize disclosure of the following information:

_____ HIV/AIDS Related Information

_____ Psychotherapy/Mental health Program Notes

_____ Genetic Testing Information Genetic Testing Information

_____ Drug/Alcohol Addiction Program Records

Disclosure of the above information is limited to the following:

☐ Time Period: _____

☐ Treatment Dates: _____

I understand that this authorization will automatically expire in 180 days from the date of my signature or upon the following event or date:

_____

- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Northwest Health and Healing. I understand that the revocation will not apply to information that has already been disclosed in response to and in reliance to this authorization.
- I understand that once the information is disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and the information may not be protected by federal privacy regulations, However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS related information, psychotherapy/mental health program notes, genetic testing information, and drug/alcohol addictions program records.
- I understand that I need not sign this form in order to ensure health care treatment, payment, and enrollment in my health plan, or eligibility for benefits.

Signature of Patient _____ Signature of person authorized by law to sign for patient _____

Date _____ Relationship to patient _____

Please select your provider: ☐ **Dr. Michael Sorah, DC** ☐ **Dr. Rolland House, DC** ☐ **Dr. Deborah Nixdorf, ND, Lac** ☐ **John Winckler, DC**

If more than 10 pages, please return by mail to: 999 NW Circle Blvd., Corvallis, OR 97330 541 754-2225

If less than 10 pages, please fax to: 541 752-9086