

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____
(Name of physician/physician group)

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

_____ Date of Birth _____
(Name of patient)

Consisting of: **Medical Records, including office notes, labs, and MRI/CT reports.**

To: **David Wilkinson, MD 9427 SW Barnes Rd #595 Portland, Or 97225**

For the purpose of: **Medical Care / Continuance of Care and treatment.**

Authorization unless your health care or treatment is for the purpose of:

- (1) Creating health information about you to be disclosed to a third party; or
- (2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Sherri Schoch at 9427 SW Barnes Road, Suite 595, Portland, Oregon 97225, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described propose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclose pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law

By: _____
(Patient)

Date: _____

By: _____
(Patient representative)

Date: _____

Description of Representative's authority: _____