AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: NAME: _____

STREET: _____

CITY,STATE & ZIP _____

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

NAME: _____ DATE OF BIRTH: _____
(Indicate maiden or former name if applicable)

consisting of : _____ Entire Health Record
_____ Chart Notes and Lab Results dated _____ to _____
_____ Other:

to: Anne Marie Moore, WHCNP
767 Willamette St, Suite 305, Eugene, OR 97401
Phone: (541) 393-2334 Fax: (541) 393-8062

by my request and for the purpose of my upcoming consultation with Anne Marie Moore, WHNP-BC.

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. However, 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, treatment or referral information.
I have read this authorization and I understand it. Unless revoked, this authorization expires one year after becoming effective.

By: _____ Date: _____ Authority: _____
If signed by a personal representative, please describe personal representative's authority.

NOTICE
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your 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 the Provider or Facility listed above at the address listed and state that you are revoking this authorization.