PACIFIC SLEEP PROGRAM

Portland Office
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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

NAME OF PATIENT:
DATE OF BIRTH:

I understand that my records are protected under state and federal confidentiality laws.
The undersigned hereby authorizes the release of protected health information described below: *(Please check only one box)*

☐ Any and all PHI, including mental health, HIV, health status or substance abuse records

☐ PHI regarding treatment for the following condition or injury, or other information (include dates)

_____

I hereby authorize:

NAME OF ORGANIZATION:	
ADDRESS:	
CITY, STATE, ZIP CODE:	
TELEPHONE:	FAX:

To provide records to OR to communicate PHI with:

NAME OF ORGANIZATION / INDIVIDUAL:	
ADDRESS:	
CITY, STATE, ZIP CODE:	
TELEPHONE:	FAX:

PATIENT INFORMATION 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 you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to our Medical Records Department at either of the above addresses and state you are revoking this authorization.

_____ _____

Patient or Legal Representative Signature Date

Please note: Legal representative must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.