AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Health information may include, but is not limited to: Appointment reminders, medication, lab results, diagnostic results, treatment plan or options.

Patient Name:_____ DOB:_____
Address:_____ City, State, Zip:_____

As required by the Privacy Laws, West Linn Primary Care may not use or disclose your protected health information without your authorization.

I hereby authorized West Linn Primary Care and any of its employees to release to/or discuss information related to my health status with: (i.e. spouse, children, chiropractor, naturopath, psychologist, etc…)

_____	_____
Name & Relationship to Patient	Information that may be disclosed
_____	_____
Name & Relationship to Patient	Information that may be disclosed

☐ **I decline**

It is okay to contact me in the following manner for lab/test results, imaging reports, and any other questions/notifications that West Linn Primary Care may have regarding my health care:

(Check all that apply)

Home Telephone #:_____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with name of clinic and call back number only

Cellular Telephone #:_____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with name of clinic and call back number only

Written Communication: **(Circle all that apply)**

Okay to send info. via: Mail, Fax, Email to: Home, Work/Office Fax#:_____

_____	_____
Signature of patient/legal representative	**Date**