



AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Know Allergy to use and disclose a copy of the specific health information described below regarding:

Patient Name: _____ **DOB:** _____

You may use or disclose the following health care information (check all that apply):

<input type="checkbox"/> All Pertinent Records <input type="checkbox"/> Consultation <input type="checkbox"/> History and Physical <input type="checkbox"/> Laboratory <input type="checkbox"/> Operative Report	<input type="checkbox"/> Pathology Report <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Billing Record <input type="checkbox"/> Other _____
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to: _____
to: _____
to: _____
to: _____
(Name and address of recipient or recipients)

Reason(s) for this authorization (check all that apply):

<input type="checkbox"/> Self <input type="checkbox"/> Change of location <input type="checkbox"/> Other (specify reason) _____ _____	<input type="checkbox"/> Continuing medical care <input type="checkbox"/> Marketing purposes
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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 Genetic testing information
 Mental health information Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION

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 when 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. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement indicating that you are revoking this authorization to:

Diana Reid, Practice Administrator of Know Allergy
at 2275 W Burnside St. Portland, Oregon 97210

SIGNATURE:

I have read this authorization and I understand it. Unless revoked, this authorization expires **1 year from date of signature.**

By: _____ Date: _____
(individual or personal representative)

Description of personal representative's authority: _____