Authorization for Disclosure of Health Information

Travel & Immunization Clinic of Portland
2330 NW Flanders, Ste 103, Portland, OR 97210
Phone: (503) 227-7771 Fax: (503) 419-9895

I hereby authorize

☐ **Travel & Immunization Clinic of Portland** or ☐ **Healthcare Facility/Provider:** _____

to disclose my information from the health records of:

Patient Name: _____
Last *First* *Middle*

Address: _____
Street *City, State* *Zip*

Phone: _____ **Date of Birth:** _____

Dates of Medical Care: _____ or ☐ All dates of care

To be disclosed to:

☐ Travel & Immunization Clinic of Portland
Attn: _____
2330 NW Flanders, Ste 103
Portland OR 97210
Fax: 503-419-9895 *Phone:* 503-227-7771

or ☐ Other: _____

Information to be disclosed:

☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Diagnostic Studies (Labs, X-ray, EKG, etc.)
☐ Progress (Chart) Notes
☐ Emergency Department Report
☐ Other _____

For the purpose of: ☐ Travel Consult ☐ Records Updating ☐ Other: _____

Please initial each paragraph:

___ I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions.

___ I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

___ I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

___ The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

___ I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment.

Expiration date or event (expires in 1 year if unspecified)***:** _____

*******Authorization for disclosure to a financial institution or employer for purposes other than payment for healthcare services expires 90 days after date signed.*

Patient Signature: _____ Date: _____

or Legal Representative: _____ Relationship to Patient: _____ Date: _____