

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) 227-7791

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 or Other: _____
Attn: _____
2330 NW Flanders, Ste 103
Portland OR 97210
Fax: 503-227-7791 Phone: 503-227-7771

Information to be disclosed:

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

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: _____