

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Information

Patient Name:

Date of Birth:

Social Security Number:

Phone & Address:

I authorize the use or disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

Health care provider's Name:

Medical Facility:

Address, Phone, Fax:

The type and amount of information to be used or disclosed is as follows:

Entire medical record ____ Progress Notes ____ Laboratory reports ____
Pathology report ____ Xray ____ Imaging studies, reports ____
Operative report ____ Personal/phone consults _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This above information may be disclosed to and used by the following individual or organization for the purpose of coordination of care:

**Daivati Bharadvaj, ND
Alive & Well Healing Arts, PC
9900 SW Wilshire St #190-D Portland OR 97225
503.484.8647
fax 503.297.3827**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of my care at this facility.

Signature of Patient or Patient's Authorized Representative (relationship)

Date