SOUTH TABOR FAMILY PHYSICIANS LLP

Electronic Copy of Health Information Request and Authorization

Patient's Name : _____ **Date of Birth:** _____

Mailing Information
Name and Address: _____ **Phone Number:** _____

_____

_____

I authorize: South Tabor Family Physicians LLP
10803 SE Cherry Blossom Drive, Portland Oregon 97216
(503) 261-7200 / Fax (503) 261-7226

To use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law specifically described below:

- ✓ All dates of service
- ✓ Including all illnesses, injuries, and well exams
- ✓ All Clinical Records (May include, but is not limited to: Office notes and exams, phone calls, laboratory/pathology results, diagnostic testing, correspondence and hospital records.)
- ✓ All Administrative Records (May include, but is not limited to demographic and limited data set of identifiable patient information, insurance information and referral information.)
- ✓ **All other records, including: Drug/substance abuse** diagnostics, treatment, or referral information. **Mental health** conditions, treatment including psychotherapy notes. **AIDS/HIV** testing or conditions including laboratory results. **Genetic** testing diagnostics, treatment, or referral information.

BY SIGNING BELOW, I ACKNOWLEDGE THE FOLLOWING:

- ***I hereby authorize South Tabor Family Physicians LLP health care providers, its employees and owners to make use or disclose my health information as indicated above.***
- ***I understand that I may revoke this authorization at any time by giving South Tabor Family Physicians LLP written notification of such revocation. However, if I choose to do so, I understand that my revocation will not affect any actions taken by South Tabor Family Physicians LLP before receiving my revocation.***
- ***I understand that I may reference South Tabor Family Physicians LLP Notice of Privacy Practices for additional information on Protected Health Information.***
- ***I have reviewed and I understand this authorization. I also understand the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.***
- ***I also understand that a copy of this authorization may be utilized with the same effectiveness as the original.***
- ***This authorization will expire: _____ days from the date of signing, or at the end of the period reasonably needed to complete the disclosure for the above described purpose.***

Authorized Signature:	*Date:*

Individuals age 18 and over must sign this release themselves. Parents must sign for children age 17 and under.