Authorization to Use or Disclose Protected Health Information

Patient Name:_________________________________Address:____

Phone:___________________________ Date of Birth: ____/____/______

I hereby authorize _________________________________to disclose my Patient Health Information to:

Robyn Kutka, ND
6464 SW. Borland Rd. Suite C-1, Tualatin, OR. 97062

Phone: 503-406-8748
Fax: 888-977-2920

Records from: *(please fill in releasing practitioner's name and office address below)*

By ***initialing*** *the spaces below, I authorize the release of the following records, if such records exist:*

____ Entire medical record
___ Progress notes
___ Laboratory report
____ Pathology reports
___ EKG
___ X-ray
____ Operative report
___ Other, Please be specific:__________________________________

The following items must be initialed to be included in other documents:
___ HIV/AIDS related record
___ Drug/Alcohol diagnosis, treatment or referral information
___ Mental Health records
___ Genetic testing information

Federal regulations require a description of how much information and what kind of information is to be disclosed: ____

For the specific purpose of (describe in detail):

____

This authorization will expire 180 days from the date of signing.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:
Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.

1. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.
6. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____ ____/_____/_____
Signature of Patient or Patient's Authorized Representative (relationship) *Date*