

**AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION**

Evergreen Natural Health Center  
6610 SW Capitol Hwy • Portland, OR 97239  
503.977.0500 (p) 503.246.1309 (f)

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **SS#** \_\_\_\_\_

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any disclosures or uses already made with your permission. To revoke this Authorization, please send a written statement to 6610 SW Capitol Hwy, Portland Oregon, 97239.

Please request my records from: \_\_\_\_\_

Address/phone: \_\_\_\_\_

Please send my records to: \_\_\_\_\_

Address/phone: \_\_\_\_\_

\_\_\_\_\_ By initialing I give permission for records to be faxed. Fax #: \_\_\_\_\_

*All faxed material does include a confidentiality statement, however this does not guarantee confidentiality on the receiving end.*

**Records I am requesting:**

- Chart notes
- Imaging reports
- Labs
- Complete Medical Chart\*
- Other \_\_\_\_\_

**For the purpose of:**

- Self (at the request of the individual)
- Continuing care
- Insurance
- Other: \_\_\_\_\_

Date Range  All  From \_\_\_\_\_ to \_\_\_\_\_

*\*External records, or records sent to us by another provider or facility are not our property and we are not legally permitted to disclose these records.*

This Authorization will expire on the earlier of \_\_\_\_\_ (date) or 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described material.

I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

The following items must be initialed to be included in the use/disclosure of your health information:

\_\_\_\_\_ HIV/AIDS                      \_\_\_\_\_ Drug/alcohol diagnosis, treatment, or referral information  
\_\_\_\_\_ Mental health                      \_\_\_\_\_ Genetic testing information

**\*\*\*Please note there may be a charge for photocopying your records.\*\*\***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_