Multnomah County
Health Department

Health Information Services
619 NW 6th Avenue, 9th Floor
Portland, OR 97209
Phone: 503-988-3997
Fax: 503-988-4088

(THIS FORM MUST BE COMPLETED BEFORE IT IS SIGNED BY THE CLIENT)

Client Name _____ AKA _____
Last First Middle Last First Middle

DOB ____ ____ / ____ ____ / ____ ____ ____ ____ ID# _____

I authorize the Multnomah County Health Department to give health records to:

Name _____

Street Address _____

City _____ State _____ Zip _____

For the purpose of: ____continuing healthcare ____legal ____disability

____other, specify: _____

List specific information to be released: _____

_____

By **initialing** the spaces below, I specifically authorize the release of the following health information, if such information exists:

____Drug/alcohol diagnosis, treatment or referral information ____HIV/AIDS related records

____Mental health related information ____Genetic testing information

This authorization will expire in one (1) year or upon _____ event.

I may revoke this authorization in writing by presenting my written revocation to the clinic or site where I received services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

I understand that if I am requesting the records for myself or my attorney there will be a fee. There is not a fee for having records sent to another medical provider.

_____ _____
Signature of client Date

_____ _____ _____
Signature of Personal Representative Date Relationship to Client

Health Information Services
AUTHORIZATION FOR RELEASE OF INFORMATION