AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

	DOB:	
PRINT name of patient above	**SS#:**	

Information to be released from:

Elevate Health	(503) 227-0350	(503) 227-0745
Name of Facility or Provider	**Phone Number**	**Fax Number**
2230 NW Pettygrove Street Suite 110	Portland, OR 97210-2659	
Address	**City, State, Zip Code**	

Information to be sent to:

Name of Facility or Provider	**Phone Number**	**Fax Number**
Address	**City, State, Zip Code**	

Information to be released. Check one:

	The most recent two (2) years of pertinent information (chart notes, labs, x-rays, and special tests)
	All medical records
	Specific information; please specify:

Purpose for which disclosure is being made. Please check one of the following:

☐ **Attorney** ☐ **Insurance** ☐ **Doctor** ☐ **Personal**

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released by initialing below:

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease

_____ HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature		**Date**	
Patient, Guardian*, or Authorized Representative*. *Please provide documents to provide authority to sign on behalf of the patient.			

This authorization will expire 90 days from the date signed.
Possible copying fee required.