## AUTHORIZATION FOR RELEASE OF INFORMATION

**Patient Information:**

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

**Information to be released from:**

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

**Information to be sent to:**

| | | |
|---|---|---|
| Elevate Health | (503) 227-0350 | (503) 227-0745 |
| **Name of Facility or Provider** | **Phone Number** | **Fax Number** |
| 2230 NW Pettygrove St. Suite 110 | Portland, OR 97210 | |
| **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)** |
| | **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.***