**AKOTS and FREDERICK, P.C.**
10200 SW Eastridge Street, Suite 101
Portland, OR 97225

# AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize Dr._____ to use and disclose a copy of the specific health and clinical information described below regarding:

_____ _____
*Name of patient* *Date of birth*

Consisting of: _____
*Describe information to be used/disclosed*

To:_____

_____
*Name and address of recipients*

For the purpose of:_____
*Describe **each** purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the patient and he/she does not provide a statement of purpose.*

This authorization will expire on the earlier of _____, 180 days from the date of signing, or the period of time reasonably needed to complete the disclosure for the purposes described above.

*Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: (1) creating health information about you to be disclosed to a third party or (2) research. 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 uses or disclosures already made. To revoke this Authorization, please send a written statement to Akots and Frederick, PC at the address above that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.*

I have reviewed and I understand this Authorization. By signing this Authorization, you are directing us to disclose your health information to another person or organization that may not have or obey the same obligations to protect privacy that we do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law. **I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.**

_____ _____
*Signature of Patient or Representative* *Date*

*Description of Representative's Authority:* _____