Allergy Clinic 511 SW 10th Avenue, Suite 1301, Portland, OR, 97205 PH:(503)228-0155 Fax:(503)226-8342

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Information

Last Name First Name MI	Date of Birth
Mailing Address:	
Phone number: **Okay to leave detailed message ▫ Yes ▫ No**	

Healthcare Facility/Provider who is Releasing Information

Name of Clinic/Provider			
Address:	City	State	Zip
Phone Number	Fax Number		

Healthcare Facility/Provider who is Receiving Information

Name of clinic			
Address	City	State	Zip
Phone	Fax Number		

You may use or disclose the following healthcare information (Check all that apply)

❑ All Pertinent Records ❑ Labs ❑ Spirometry	❑ Skin Tests ❑ X-rays/CT reports ❑ Office visit (last 2 years)

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization , the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, the authorization will expire on the earlier of 1 year from the date of signing or on_____(Date).

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Print Name (If other than patient, proof of authority is required.) Relationship to patient