PROactive
PHYSICAL THERAPY SPECIALISTS
1480 NE Village Street
Fairview, OR. 97024
Phone: 503-489-5007
Fax: 503-489-1650

Authorization for the Disclosure of Health Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Number: _____ Evening Number: _____

I authorize Proactive to disclose a copy of my specific protected health information as described below:

Name/Facility: _____

Address: _____

Phone number: _____ Fax number: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information disclosed. (Circle)

Yes No Alcohol/drug diagnosis, treatment or referral information

Yes No HIV/AIDS information

Yes No Mental Health information

Yes No Genetic testing information

Purpose for disclosure (circle): Personal Record Legal Insurance Continuation of Care

Other (please describe): _____

Specific information to be disclosed:

_____

_____

_____

_____

Dates of treatment from: _____ To: _____ **OR** _____ All past, present and future records

Disclosure method requested (initial one):

_____ Copy of protected health information mailed to: Address above

_____ Copy of record to be picked up; date for pick up: _____

_____ Fax a copy of record (Healthcare provider or Attorney only): _____

_____ E-mail (unsecured format, i.e. Gmail, Hotmail): _____

_____ CD

You may request that an electronic record be sent, however, be advised that unencrypted CD or email is not secure and can be opened and read by parties other than you.

By signing this authorization form, I understand that:

- I understand there may be a fee associated with this request.
- I understand that I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to ProActive ATTN: Privacy Officer, 1480 NE Village Street, Fairview, OR. 97024. However, revocation will not have an effect on any actions ProActive took before it received the revocation.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state laws regarding the privacy of my protected health information.
- I understand that treatment, payment, enrollment or eligibility may not be conditioned on whether I sign this authorization.
- This authorization will remain in effect until:

  _____ (date/event/condition specified by the patient).
  If I fail to specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.
- I understand I have a right to a copy of this authorization; a copy of this authorization is valid as an original.

_____

Patient or Authorized Representative Signature Date

_____

Print Name Relationship to Patient