

356 SE 9<sup>th</sup> Ave Hillsboro, OR 97213 www.HillsboroClinic.com 503.681.4366 (phone) 503.681.4374 (fax)

Dr. Marc E. Lewis Dr. Meenakshi Aggarwal Anne Dunne, DNP Melinda Sanfilippo, FNP

Patient:		DOB:	
Authorization to Release Medical Information			
I hereby authorize:		se ividucul inition	
Hillsboro Clinic			
356 SE 9 <sup>th</sup> Ave			
Hillsboro, OR 97123			
To provide medical information	to: Beyon	d Health LLC.	
(Name of Facility)	5160 Laidl	d Health LLC. aw Rd Suite 22	4
(Address)	ortland, C	R 97229	
(City, State, Zip Code)	Control of the Association of the Control of the Co		
Data Requested:			
	ntire Record		ging Reports
	istory & Physical	Other	
0	perative/Pathology	Reports	
For the purpose of:			
HIV Test in Drug/alco	results & related info hol diagnosis, treatn alth treatment inform	ne release of the following confidormation or referral information nent or referral information mation	ential information:
(Patient Signature)	(Date)	(Parent/Legal Guardian)	(Date)
<b>Rights:</b> I understand that I may re ability to obtain treatment. I may i authorization in accordance with c	ect to re-disclosure by fuse to sign this autho nspect or copy any inf organizational policy. I	ds for the purpose stated above. I ur the recipient and may no longer be orization and that my refusal to sign formation to be used and/or disclose further understand that I have the ri t that action has been taken on this a	protected. will not affect my ed under this ight to revoke this
(Patient Signature)	(Date)	(Parent/Legal Guardian)	(Date)
Permission to fax and/or sen All faxed materials will contain a co		YesNo nt, however, I understand confidentia	ality at the receiving