HILLSBORO CLINIC
Excellence in Primary Care

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PATIENT: _____ DOB: _____

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize Hillsboro Clinic to use and disclose a copy of the specific health and medical information described below regarding:_____
(Name of Patient)

consisting of any and all medical records, including billing, to:

_____
(Name of Recipient or Class of Recipients)

_____ _____
(Recipient's Relationship to Patient) (Recipient's Phone Number)

for the purpose of coordination of patient care.

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) for the purpose of 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 with your permission. To revoke this Authorization, please send a written statement to Hillsboro Clinic that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you revoking this Authorization.
This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date:_____
(Patient Signature)

-OR-

By: _____ Date:_____
(Patient Signature)
Description of Representative's Authority:_____