CALYPSO NATURAL CLINIC

2274 SW 2nd St. suite C

McMinnville, OR 97128

Telephone 503-472-5500 Fax 503-434-1224

Authorization to use and disclose protected health information

All sections of the authorization must be completed or the authorization will not be accepted

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Name of Doctor, Practice or Agency Releasing the Health Care Information

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Address of person/entity

City, State, Zip Code Phone Fax

To use and disclose a copy of the specific health information described below regarding:

Name of patient date of birth social security #

Address of patient patient's phone number

City, State, Zip Code

Consisting of: Dates of Health Care Information to be released: From (date) _______To___________

(Check all that apply)

____Clinic notes _____Consultation reports

____History and Physical exams _____Operative reports

____Discharge summary _____X-ray/Diagnostic images

____Laboratory Reports _____EKG/EEG

____Other_______________

To: _____Amanda L Hoffman ND of Calypso Natural Clinic

To:_____ Julie Glass ND of Calypso Natural Clinic

Name of Doctor, practice, agency or person who is to receive this health care information

__ 2274 SW 2nd Street Suite C

Address of recipient

_______McMinnville OR 97128

City, State, Zip

Purpose of request ___Treatment/Consultation ___Transfer of Care ___ Billing or Claims ____At the request of Patient

____ Other____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted diseases, hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. ___YES (Initials) ___NO (Initials)

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus Acquired immunodeficiency syndrome) testing and/or treatment, I agree to its release. ___YES (Initials) ___NO (Initials)

Time Limit & Right to Revoke Authorization: This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services unless specified above under Purpose of Request. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to the Privacy Officer at 2274 SW 2nd St., McMinnville, Oregon 97128 and state that you are revoking this authorization.

Re-disclosure: I understand that the information used or disclosed pursuant to this authorization maybe subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it. Unless revoked this authorization will expire 180 days or on the following date or event:

The _____day of ___________, 20________

Signature of

patient____Date___________________________________

Description of relationship to patient____