Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I, ________________________________, authorize Morlen Health to use and/or disclose certain protected health information (PHI) about me to (provide names of friends, family members, or others who you are authorizing to receive information):

____

____

____

This authorization permits Morlen Health to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.):

____

____

____

The information will be used or disclosed for the following purpose(s):

____

If requested by the patient, purpose(s) may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [date]: _________________________________, or defined event.

I do not have to sign this authorization to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted in to Morlen Health, Compliance Office, 401 NE 19th Ave., Suite 200, Portland, OR 97232.

Signed by: ____

Relationship to Patient: ____

Date: ____