Armstrong
WELLNESS

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I desire to release the medical information for the patient indicated below for the purposes of establishing and coordinating care and updating records maintained at Armstrong Wellness. I understand that my establishing or receiving medical care is NOT contingent upon signing this form. I understand the release of this information is intended to assist the providers at Armstrong Wellness to care for the patient indicated below.

I understand this authorization may be revoked in writing at any time by providing a written statement to the address above. No revocation will be retroactive to pertain to records already released. This consent will expire one year from the date of signing unless otherwise indicated.

I understand the information used or disclosed may be subject to re-disclosure except for highly confidential information to include "Sensitive Information". The undersigned hereby releases Armstrong Wellness from any liability which may arise from the release and/or examination of the information indicated above. I have read this authorization, and I understand it.

I authorize _____ to release a copy of medical information
Hospital/Health Care Provider

For: _____ _____ _____

Name of Patient Date of Birth Telephone Number

For the purpose of: ___ Patient Care ___ Other: _____

To: **Armstrong Wellness, 3000 Market St. NE Suite 530, Salem, Oregon 97301**
Phone (503) 581-1198, Fax (503) 339-9565

By placing my <u>initials</u> in the spaces below, I indicate my approval for the release of the following medical records (*<u>for the past 5 years</u>*), if such exist, to be sent.

_____ Office Visit Notes/Chart Summaries _____ Lab and Diagnostic Results
_____ Current Medication List _____ Other: _____

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

_____ _____
Signature of patient or person authorized by law Date:

Relationship to Patient: ___ Self ___ Parent/Legal Guardian ___ Personal Representative

Revised 5/2013