1510 Division St., Suite 280, Oregon City, OR 97045
PHONE (503) 905 3400, FAX (503) 905 3399

200 Hazel Dell Way, Suite 202, Canby, OR 97013
PHONE (503) 266.8500, FAX (503) 266.8585

Timothy Jeffreys, MD - Dilek Bishku, MD - Christine Guenzi, MD - Jennifer Shepard, MD - Laura Montez, PA-C

Authorization to Use and Disclose Protected Health Information

All sections of this form must be completed, or the authorization will not be accepted.

I authorize **Willamette Falls Pediatric Group** to

☐ Send/Disclose Records **to**:
☐ Receive/Use Records **from**:

Name/Facility _____ Address_____

_____ Phone_____ Fax_____

Name of Patient _____ Date of Birth_____

Consisting of: Physician Reports _____ X-rays _____ Labs _____ ED _____ Billing _____ Other _____

For the purpose of: Continued Care _____ Legal _____ Disability _____ School Entry _____ Other_____

*If the information to be discussed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the space next to the type of information.
HIV/AIDS _____ Mental Health _____ Genetic Testing _____ Drug/Alcohol Treatment, Diagnosis, or Referral _____

You are not required to sign this authorization. Refusal to sign this authorization will not adversely affect your ability to receive health care services. The only circumstances when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

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 purpose described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement of revocation to Administration, WFPG, 1510 Division St., Suite 280, Oregon City, OR 97045.

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

This authorization expires one year from the date of signature unless revoked or otherwise specified below.

By: (Individual or personal representative): _____

Description of personal representative's authority: _____ Date: _____