AUTHORIZATION
TO DISCLOSE HEALTH INFORMATION

I authorize: **JAMES W BAKERMD LLC**
DBA: Baker Allergy, Asthma and Dermatology
9495 SW Locust Street Suite A Portland, OR 97223
Phone: 503-636-9011 Fax: 503-636-3952

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

_____

(Name of Patient) (Date of Birth)

Consisting of: _____

(Describe information to be disclosed)

To: _____

_____

(Name, Address, Phone Number, Fax Number of Physician/Group/Legal Agency)

For the Purpose of: _____

(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and individual does not, or elects not to, provide a statement of purpose)

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 disclose information about you for the reasons covered by your written authorization, but we cannot take back any disclosures already made with your permission.

This Authorization is valid until: _____ (date)

I have reviewed and I understand this authorization. I also understand that the information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

By: _____ _____

Signature of Patient Date

-OR-

By: _____ _____

Signature of Patient Representative Date

Description of Representative's Authority: _____