Baker Allergy, Asthma & Dermatology
Authorization to Use or Disclose Protected Health Information (PHI)

Incoming Records Request

*I authorize:*_____phone_____fax_____
address _____ *to disclose the following information from the health records of :*

The individual for whom this authorization is being requested. Please complete the following:	
_____ Name	_____ Chart #
_____ Address	_____ City _____ State _____ Zip
_____ Area Code & Telephone Number	_____ Date of Birth
Dates of Service: From _____	***To*** _____

Information Requested	
□ All Pertinent Records □ Assessments □ Consultation □ History & Physical □ Operative Report	□ Pathology Report □ X-Ray Reports □ Billing Record □ Other _____

Purpose:

□ Self □ Continuing Medical Care □Attorney Request
□ Other: (specify reason)_____

Information to be Given to:

Baker Allergy, Asthma & Dermatology
9495 SW Locust Street, Suite A
Portland, OR 97223
Phone 503-636-9011
Fax 503-636-3952

- I understand that I may refuse to sign this authorization form. Your health care and payment for that health care cannot be conditioned upon receipt of this signed authorization
- I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Baker Allergy, Asthma & Dermatology Notice of Privacy Practices explains the process for revocation, which includes a request in writing to 9495 SW Locust Street, Suite A, Portland, Oregon 97223.
- Unless I revoke this authorization earlier, **it will expire 6 months from the date signed or as specified**: Date: _____.
- I understand that if this information is disclosed to a third party, the information may no longer be protected by the state and federal regulations and may be re-disclosed by the person or organization that receives the information.
- I release Baker Allergy, Asthma & Dermatology, their employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ Signature of the Patient _____ Date

_____ Signature of the Legal Representative _____ Relationship to Patient