

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

**Outgoing Records Request**

*I authorize Baker Allergy, Asthma & Dermatology 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 _____	
<i>Dates of Service: From</i> _____		<i>To</i> _____	
Information Requested			
<input type="checkbox"/> All Pertinent Records <input type="checkbox"/> Assessments <input type="checkbox"/> Consultation <input type="checkbox"/> History & Physical <input type="checkbox"/> Operative Report		<input type="checkbox"/> Pathology Report <input type="checkbox"/> X-Ray Films <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Billing Record <input type="checkbox"/> Other _____	
Purpose:			
<input type="checkbox"/> Self <input type="checkbox"/> Other: (specify reason) _____		<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request	
Information to be Given to:			
Company, Person, Facility _____		Phone Number _____	Fax Number _____
Address _____		City _____	State _____ Zip Code _____

- 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