BAKER
ALLERGY · ASTHMA
DERMATOLOGY

Authorization to Use or Disclose Protected Health Information (PHI)

RECORDS RELEASE

RELEASE MEDICAL RECORDS TO / FROM (Please Circle):	RELEASE MEDICAL RECORDS TO / FROM (Please Circle):
Baker Allergy, Asthma & Dermatology Name	_____ Name
9495 SW Locust Street, Suite A Street Address	_____ Street Address
Portland, OR 97223 City, State, Zip Code	_____ City, State, Zip Code
503-636-9011 503-636-3952 Phone Number Fax	_____ Phone Number Fax

PATIENT INFORMATION

_____ _____ _____
Patient Name Date of Birth Phone Number

_____ _____ _____ _____
Address City State Zip

_____ _____
Patient Legal Guardian (If Applicable) Relationship to Patient

INFORMATION REQUESTED

□ All Pertinent Records □ X-Ray Reports □ Consultation □ History & Physical □ Last 2 Years Complete Records

□ Pathology Reports □ Assessments/Chart Notes □ Billing Record □ Operative Report □ Other (specify):_____

PURPOSE

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

- 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 Patient Date

_____ _____ _____
Signature of Legal Representative Relationship to Patient Date