

**Authorization to Disclose My Health Care Information to
Hosseinion Family Medicine, LLC.**

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization:

Please disclose the following:

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

Health care information in my medical record for the date(s): _____

Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

Please send this health care information to:

Hosseinion Family Medicine, LLC.
3942 SE Hawthorne Blvd
Portland, OR 97214
Phone 503-234-2070
Fax 503-235-3956

The healthcare information requested is to be used by Hosseinion Family Medicine, LLC., for my continued healthcare.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Hosseinion Family Medicine, LLC. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Hosseinion Family Medicine, LLC. Or
- Write a letter to Hosseinion Family Medicine, LLC.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

Last Update: __1__ / 12__ / 2007__ This release expires one year from date of signature.