AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Last Name: _____First Name: _____ MI: _____
DOB:_____Phone:_____
Address:_____

I Authorize information to be released **FROM:**
Facility/Doctor: Kirana Kefalos MD
Address: 2455 NW Marshall St. Suite 12, Portland, OR 97210
Phone #: 503-227-2200 Fax: 503-227-5150

Please send my records **TO:**
Facility/Doctor:_____
Address:_____
Phone #:_____ Fax: _____

Specifically, I authorize the use or disclosure of the following information:
_____Complete Record _____Imaging Reports _____Chart Notes
_____Hospital Records _____Procedure/ Surgery Reports _____Labs
_____Other _____
_____Other _____

Date ranges of records being disclosed: From:_____ To:_____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By *initialing* the lines below, I authorize the release of the following protected or sensitive information:
_____ Information regarding the patient's diagnosis and treatment of HIV/AIDS
_____Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Treatment of alcohol or drugs abuse reports

This protected health information is being used or disclosed for the following purpose:
___ Continuing Care ___Personal Use ___Legal___Other_____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Clinic will not condition my treatment, payment, enrollment in health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under the applicable federal and state law. I understand that I also have the right to refuse to sign this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
To the extent permitted by law, the Clinic, It's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient/Personal Representative Relationship to Patient

_____
Date