AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
CORNELL FAMILY MEDICINE
12400 NW CORNELL RD. SUITE 200, PORTLAND OR 97229

PHONE: 503-352-0211 FAX: 503-352-1976

I, (patient name)_________________________________dob_____________
Hereby authorize and consent to allow Cornell Family Medicine to disclose information contained in, provide access to, or provide such photocopies as may be requested of my protected health and/ or billing information to the person or organization listed below:

Release from:	Send to:
______________________________	______________________________
Physician	Physician
______________________________	______________________________
Address	Address
______________________________	______________________________
City, state, zipcode	City, state, zipcode
______________________________	______________________________
Phone or Fax	Phone or Fax

The purpose or need for this release of information is ____________________

The specific information to be used or disclosed is:

___lab reports	___x-ray reports	___chart notes
___immunizations	___hospital records	___history & physical
___pathology records	___entire last 2 years	___physical therapy

___other, please specify ____

Please initial the following box to consent to the release of psychological, psychiatric, alcohol, drug abuse and HIV/aids information.
____initial

______________________________	______________________________
Signature of patient or representive	date signed
______________________________	______________________________
Address	telephone number
______________________________	release expires 180 days from date signed
City, State, Zip code	