The Portland Clinic

PATIENT LABEL

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize VERBAL disclosure of the named individual's health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

The Portland Clinic, LLP is authorized to verbally disclose protected health information (PHI) pertaining to my, Medical Status, Health condition, and my Financial information.

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.

_____ DRUG ABUSE DIAGNOSIS/TREATMENT _____SEXUALLY TRANSMITTED DISEASES

_____ ALCOHOLISM DIAGNOSIS/TREATMENT _____ MENTAL HEALTH TREATMENT

_____ AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH-RISK BEHAVIOR _____GENETIC TESTING

The Portland Clinic, LLP, may disclose verbally my PHI as marked above to the following individual(s) or organization(s):

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Purpose of Request:

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: If this authorization has not been revoked, it will be terminated two years from the date of my signature unless a different expiration date or expiration event is **stated below**.

☐ Expiration Event: (Upon my death, no expiration, etc.)

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

If I have any questions about disclosure of my health information, I can contact the Privacy Officer at 503-221-0161.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient