Serene Care Clinic
10201 S.E. Holgate St.
Portland, OR 97266
Telephone: 503-762-1122 Fax: 503-762-1155

Authorization to Use or Disclose Protected Health Information

Patient Name:_____ Address:_____

Phone:_____ Date of Birth_____ Date Requested_____

Date of Expiration:_____ (If no expiration date is specified, this authorization will expire in 120 days)

As required by the Privacy Regulations, Serene Care Clinic may not use or disclose your protected health information except as provided in our Notice of Privacy Practices (shown in Serene Care Patient Intake form) without your authorization.

I hereby authorize: _____

Address: _____
Street Number City State Zip

Fax Number_____ Phone Number_____

To disclose my Protected Health Information to: Serene Care Clinic

Mail or Fax to: **Serene Care Clinic**
10201 S.E. Holgate St.
Portland, OR 97266
Telephone: 503-762-1122 Fax: 503-762-1155

By initialing the spaces below, I authorize the release of the following medical records, if such records exist:

____ Entire medical record **____Progress notes** **____Laboratory Reports**
____Pathology reports **____EKG** **____X-Rays**
____Operative report **____Other (Please Specify)_____**

The following items must be initialed to be included in other documents:

____HIV/AIDS related records **____Mental Health records**
____Drug/Alcohol diagnosis, treatment or referral information **____Genetic testing information**

(Federal regulations require a description of how much information and what kind of information is to be disclosed)

For the specific purpose of (describe in detail):_____

I understand that the information disclosed above may be redisclosed to additional parties and no longer protected for reasons beyond our control.

Patient Signature_____