**Merritt Health & Wellness, LLC**

**Functional Medicine and Primary Care Clinic**

**6035 SE Milwaukie Ave, Portland, OR 97202**

**Ph: 971-258-1120 Fx: 866-309-2838**

**Authorization to Disclose Protected Health Information**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

I authorize Merritt Health & Wellness, LLC to (circle one) **Release records to** OR **Request records from:**

Provider/Facility Name/Individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please ***initial*** the information you want disclosed:

\_\_\_Entire medical record (all information) to the above named recipient

\_\_\_Records related to (specific dates, medical conditions etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Most recent 5 year history \_\_\_Diagnostic Imaging Reports (x-rays, MRI, etc.)

\_\_\_Laboratory/Pathology findings \_\_\_Clinical chart notes

\_\_\_Last 2 yrs of lab findings and chart notes relating to underlying treatment of metabolic issues.   
\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of the use/disclosure is for **continuity of care.**

If the information to be disclosed contains the type of records or info listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this info will be disclosed if I place my ***initials*** in the applicable space next to the type of information.

\_\_\_HIV/AIDS \_\_\_ Mental health information

\_\_\_Genetic testing information \_\_\_\*Drug/alcohol diagnosis, treatment, or referral information

\*Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. I understand I may revoke this authorization in writing at any time. The only exception is when information has already been released in response to this authorization.

I also understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under the other applicable state or federal laws and regulations.

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Signature of Patient/Authorized Individual Date

If signed by other than patient, indication relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_