AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ____
Last First MI Maiden or Other Name

Date of Birth: ____-_____-_____ Patient Account #:_______________ Phone: ______________________

Address: _________________________________City: __________________State: _______Zip:_________

☐ **I authorize** Dr. Tyler L. Clark, located at 9430 SW Coral St., Suite 200, Tigard, OR 97223, to disclose the following records or information related to the date(s) below:

□ All Dates of Service □ Specific Date(s) or Date range :_____________________________

Records: □ All records
□ Billing/Claims Records
□ Clinical/Health Care Records
□ Other (please list)____

Please release these records to:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Practice Name (if records are to be sent to a provider)____

Address: ____

City:___________________________ State:__________ Zip Code :_____________________

Phone: (____)___________________Fax:______________________ Email: _____________________________

If the person or entity you are authorizing to receive this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to the individual(s) or institutions, per your request, and is no longer protected by state and federal privacy regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:
Dr. Tyler L. Clark Fax: (503)473-8300
9430 SW Coral Street, Suite 200
Tigard, OR 97223

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.
You have the right to receive a copy of this authorization.
This authorization expires as follows:
□ One year from date of signing
□ When I revoke this authorization, in writing
□ Other _____________________________

____________________________________ ____________
Patient or Legal Representative Signature Date

____
Print Patient or Legal Representative Name/Relationship

A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original