Haylee Nye, ND
Bethany Mattson, ND
Emma Kingsberg, ND
Krista Barlow, MSN

Floryn Health
1730 SW Skyline Blvd Portland, OR 97221
P (503) 451 - 5013 F (855) 508 - 2848
florynhealth.net

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the use and/or disclosure of my protected health information (medical records) described below:

PATIENT NAME:_____ DOB:_____

I authorize the following facility/provider to RELEASE my protected health information (Please include name, address, phone/fax number)**:**

_____

I authorize the following facility/provider to RECEIVE my protected health information:

Floryn Health, 1730 SW Skyline Blvd, 110, Portland OR 97221, F: (855) 508-2848

The purpose of the release is:

____At the request of individual ____Diagnostic Evaluation ____Coordination of Care ____Change of Physician

____Other:_____

The following information may be released:

____All medical records ____Labs ____Problem list ____Imaging ____Medical Summary

____Progress Notes ____Medication Records ____Operative reports ____Pathology

____Other_____

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

____HIV/AIDS information ____Genetic testing information ____Mental Health information

____Drugs/alcohol diagnosis, treatment, or referral information

Please send my records for the following Dates of service: From:_____ through_____.

- ✓ This authorization will expire 180 days from the date signed.
- ✓ You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any disclosures already made with your permission. To evoke your records release with this authorization, please mail a written statement to our clinic that identifies the date you signed the authorization, the recipient of the information in the authorization and state you are revoking this authorization.

I have reviewed and I understand this authorization. I also, understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____
(Signature of patient or representative) Relationship (if signed by representative)

_____
(Date)