Hawthorn Healing Arts Center, LLC
39 NW Louisiana Ave., Bend, OR 97703
Phone: (541) 330-0334 Fax: (833) 857-1937

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this information

_____ _____ _____
Patient Name DOB Phone #

I authorize _____Hawthorn Healing Arts Center_____

To release this information to: _____
Name & Address of Facility or Provider

_____ _____
Phone Fax

For the purpose of: _____

By **initialing the space below**, I specifically authorize the release of the following medical records:

_____ Chart Notes _____ Lab Results _____Billing Statements

_____ Other (please specify) _____

Please include dates from _____ to _____

OR

By initialing, I authorize the direct communication between practitioners regarding my entire plan of care _____
Or specifically related to _____

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

_____ HIV/AIDS related records _____Mental health information _____Drug/alcohol diagnosis

_____ Genetic testing information _____ Psychotherapy notes

I understand that the information disclosed pursuant to this authorization may be re-disclosed and no longer protected if the recipient is not subject to federal privacy regulations. You have the right to revoke this Authorization at any time, provided that 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 uses or disclosures already made with your permission. This Authorization will expire 180 days from the date of signing or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have read this Authorization and I understand and agree to it.

_____ _____
Date Signature of Patient or Personal Representative