Tuality Physicians, Family Practice and Urgent Care
HIPAA Authorization Form for Disclosure of Protected Health Information (PHI)

This form, when signed at my request, will authorize Tuality Physicians to disclose specified Protected Health Information (PHI)

1. I hereby authorize the disclosure of the following patient's PHI:

   Patient Name: _____

   Patient Date of Birth: _____

2. The following organization, agency or individual(s) is/are authorized to receive this PHI:
   Doctors Office
   Employer
   Lawyer
   Family Member- Specify by Name & Relationship: _____
   Other: _____

   The authorized recipient(s) named above may not re-disclose this PHI unless authorized by the patient. Patient shall hold harmless Tuality Physicians in the event the authorized recipient(s) makes a non-permitted use or disclosure of this patient's PHI.

3. Please check the follow information to be disclosed:

Documents	**Dates of Service (Optional)**
_____ Complete Medical Care	_____
_____ Immunizations	_____
_____ Labs	_____
_____ Imaging	_____
_____ Correspondence	_____
_____ Other	_____

4. The patient or legally authorized representative MUST INTIAL BELOW to acknowledge the following statements:

_____ I understand that I generally may revoke this authorization at any time by written notification to:

Tuality Physicians Family Practice and Urgent Care
ATTN: Medical Records
900 SE Oak St Suite 202
Hillsboro, OR 97123

_____ Unless otherwise revoked, this authorization will expire **ONE (1) YEAR** from the date signed below or on the following date: ___/___/____.

_____ I understand that Tuality Physicians will maintain the original of this authorization in the patients file.

By signing below, I am attesting that I have the legal right to authorize the release of this patient's PHI.

Signature: _____ **Date: _____**

Printed Name: _____

_____

Relationship to Patient (If signing as legally authorized representative)

Signing this form will not affect treatment from Tuality Physicians