Tuality Physicians, PC
900 SE Oak St Suite 202 Hillsboro, OR 97123
Tele (503) 640-3724 ~ Fax (503) 648-8982

AUTHORIZATION TO RELEASE INFORMATION - GENERAL

Name: DOB: Phone #:

PLEASE OBTAIN INFORMATION FROM:

Name of Provider/Clinic/Organization

Street Address

City, State, Zip Code

Phone Fax

PLEASE SEND INFORMATION TO:

Tuality Physicians, PC
900 SE Oak St. #202
Hillsboro, OR 97123

I hereby authorize disclosure of my protected health information as follows: (Please check one)

- ☐ **Complete Medical Records including all electronic & paper records (for all services)**
- ☐ **HIV Test Results** Required for Travel Abroad/Visa and Entry Requirements
- ☐ **Mental Health, Genetic Testing, Drug/Alcohol diagnosis, treatment and/or referral information**
- ☐ **Records only related to the following services:** ____________________

The purpose of this disclosure is: (Please check one)

- ☐ Transfer of records to another provider for future care
- ☐ Legal
- ☐ Job
- ☐ Personal Use
- ☐ Other (describe) ____________________
- ☐ School

Expiration of this Authorization: (Please check one)

- ☐ 90 days after signature date
- ☐ On this date: ___ / ___/ ___
- ☐ When this event happens: ____________________

ADDITIONAL PATIENT INFORMATION

I understand that I have the right to withdraw this authorization. To withdraw, please sign below.
I understand that I do not have to sign this authorization to get treatment
I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Tuality Physicians, PC.
I understand that signing this authorization does not cancel any rights I have under state or federal laws.

Patient Signature (Parent or Legal Representative, if applicable) Date

I wish to withdraw this authorization: ____________________ Date

Witness Signature: ____________________ Fee: ________

________ Pick up records ________ FAX records ________ Mail Records