Authorization to Release Medical Information

I hereby authorize: ____
____
____

to use and/or disclose my protected health information as described below to:

Pacific Allergy & Asthma
Alexander Yu, MD, PhD
5040 SW Griffith Dr #201
Beaverton, OR 97005
Fax: (570) 243-0932
Phone (503)486-4481

For the following purposes: ________________________ (or choose below)

☐ Transfer of care ☐ Personal Use ☐ Litigation/Legal ☐ Insurance

Type of Information to be Disclosed

☐ Entire Medical Record	☐ Most Recent 5 year History	☐ Laboratory Reports
☐ Office Chart Notes	☐ History and Physical Exam	☐ Pathology Reports
☐ Billing Statement	☐ Medical Records for Continuity of Care	☐ Operative Reports
☐ Consultation	☐ Discharge Summary	

☐ Other ____

If you do not want certain portions of your medical records released, please check the categories below that you would like EXCLUDED:

☐ HIV/AIDS/STDs ☐ Drug/Alcohol abuse ☐ Genetic Testing ☐ Mental Health Treatment

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.

I understand that this authorization is voluntary and I may refuse to sign this authorization without affecting my health care or the payment for my health care.

This authorization will expire 180 days from the date of signature or (insert date)_________

Patient Name______________________________ Date of Birth_________

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Signature of Patient or Legal Representative Date

Printed Name of Patient's Representative ______________________________

Relationship to patient:______________________________