

(PLEASE: PRINT AND FILL OUT THIS FORM. THEN, FAX IT TO 503-357-4831)



**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name \_\_\_\_\_, \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last First MI MM/DD/YYYY  
Medical Record #: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Please RELEASE information FROM:**  
(Person or facility which has health information)

**Please RELEASE information TO**  
(Person or facility to receive health information)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Arcoma Gonzalez Lambert N.D./Blossoming Health  
1911 Mt View Ln. Suite 300  
Forest Grove, OR 97116  
Phone: 503-357-2826 Fax: 503-357-4831

**Please specify the health information you authorize to be released:**

Type(s) of health information: \_\_\_\_\_  
Specify date(s) of treatment or time period: \_\_\_\_\_  
**Please describe the purpose of this release:** \_\_\_\_\_

**The following information will not be released unless you specifically authorize it by *initialing* the relevant line(s) below:**

- \_\_\_\_\_ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.  
Initial
- \_\_\_\_\_ I specifically authorize the release of HIV/AIDS test results.  
Initial
- \_\_\_\_\_ I specifically authorize the release of genetic testing information.  
Initial

**Expiration of Authorization:** Unless otherwise revoked, this Authorization expires on \_\_\_\_\_.  
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

*Please read the important notice concerning your rights on the following page.*

**Signature:**

_____ Signature (Patient, Parent, Guardian)	_____ Print Name	_____ Date	_____ Time
_____ Relationship to Patient (Parent/Guardian/ Conservator/Patient Representative)	_____ Witness (if patient unable to sign) or Interpreter	_____ Phone Number	

**NOTICE:** Blossoming Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**YOUR RIGHTS:** This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Blossoming Health 1911 Mt View Ln. Suite 300 Forest Grove, OR 97116 or fax it to 503-357-4831. The revocation will take effect when Blossoming Health receives it, except to the extent Blossoming Health or others have already relied on it.

You are entitled to receive a copy of this Authorization.

Initials:\_\_\_\_\_