Boulder

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the use and disclosure of health information about you. Failure to provide all information requested may invalidate this Authorization.

Patient Name: _____

DOB: _____

I hereby authorize Boulder Care Provider Group, P.A., located at 111 SW Naito Parkway, Ste 200 Portland, OR 97204 to disclose all health information pertaining to my medical history, physical condition, and treatment received, including demographic information, to the following individual(s) or organization(s):

Individual or Organization Name:

_____

Address: _____

Phone Number: _____

I specifically authorize Boulder Care Provider Group, P.A. to share the following medical, behavioral and/or substance use disorder information (check as appropriate):

□ Medical records (including provider notes and diagnoses including substance use disorders)
□ Medication list (including medications to treat opioid use disorder, such as methadone or buprenorphine/Suboxone)
□ Lab and/or imaging results (including drug screen results)
□ HIV results if available
□ Mental health records
□ Other:

_____

The information identified in this Authorization may be disclosed so that the individuals and organizations listed above can coordinate my substance abuse

and mental health treatment services. This Authorization is valid for one (1) year from the date of signature below.

I understand that, except to the extent that a lawful holder of my information has acted in reliance on this Authorization, I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Boulder Care Provider Group, P.A.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by Federal or State law. I understand that my substance use disorder information may not be re-disclosed unless another authorization for disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law. Boulder Care Provider Group, P.A. will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to: inspect or copy the protected medical information to be used or disclosed as permitted under Federal or State law; refuse to sign this Authorization; and receive a copy of this Authorization. If I am requesting information for myself or for a third party, a reasonable and appropriate fee may be assessed for copying the information. I have read the above information and authorize the disclosure of my information by Boulder Care Provider Group, P.A. for the purpose described herein.

By signing below, I acknowledge that I have read and agree to the terms of this Authorization.

_____ _____ Signature of Patient or Delegate Date

If you are not the patient, describe your authority to sign on behalf of the patient:

_____