## Authorization to Release, Receive, Use, Disclose or Exchange Health Information to/with/from

**Project Quest dba Quest Center for Integrative Health**
**2901 E Burnside, Portland, OR 97214 Phone: (503) 238-5203 Fax: (503) 238-5202**

Client Legal Name: ____________________ ____________________ ____ Date of Birth: ______/______/__________
**Last** **First** **MI**

Preferred Name/AKA: ____________________ ____________________ ____
**Last** **First** **MI**

**I authorize** Project Quest, dba Quest Center for Integrative Health: **Check appropriate box (es) & give complete name & address**

[ ] **To give/send medical-related information to:**

[ ] **To receive medical-related information from:**

[ ] **To verbally exchange medical-related information with:**

**Provider/Entity Name: ________________________________**

**Address: ______________________________________________**
**______________________________________________________**

**Phone: (__________) - ___________ - _______________**

**Fax: : (__________) - ___________ - _______________**

**Specialty: ________________________________________**

**Via the following method:** ***(Mark all that apply)***
[ ] U.S. Mail [ ] Facsimile [ ] Pick up

**For the following purpose:** ***(Mark the appropriate space below)***
[ ] Continuity of Care [ ] Treatment [ ] Evaluation [ ] Housing [ ] Legal [ ] Review [ ] Personal [ ] Other: ________________

**Information to be Disclosed:** *(**Initial** the appropriate spaces below)*

____ Entire Medical Records _____ All hospital records _____ Transcribed hospital records _____ Emergency/Urgent Care

____ Most Recent 5-year history _____ Emergency/Urgent Care _____ Diagnostic Imaging Reports _____ Laboratory Reports

____ Pathology Reports _____ Medication Records _____ Current Medication List _____ Billing Info./Statements

____ Records for time period: _____/____/_____ to ____/____/_____[ ] SUD Records [ ] MH Records [ ] Medical [ ] All

____ Records regarding the treatment of: __________________________ [ ] SUD Records [ ] MH Records [ ] Medical [ ] All

____ Records related to a MVA claim from:_____/____/____ to____/____/____ [ ] SUD Records [ ] MH Records [ ] Medical [ ] All

____ Other (specify): ____________________________________________________________________

I understand that I have the right to revoke this authorization, at any time, provided that I do so in writing, and provided it is directed to the entity responsible for this authorization. If I choose to revoke this authorization, it will no longer be used for the reasons covered by this authorization. I understand that disclosures/uses/releases made prior to revoking this authorization cannot be rescinded. I understand that I do not have to sign this authorization. I understand that if I choose not to sign this authorization, my health care and payment for that health care cannot be conditioned upon receipt of this authorization and will not be affected.

To revoke this authorization, please contact your provider or medical records at Quest Center for Integrative Heath at 2901 E Burnside, Portland, OR 97214. Please state you are revoking this authorization.

This authorization will expire (1) **90 days** from the date I am no Longer in Treatment within Project Quest, or (2) the date specified below:
**Specified Expiration Date: _________/_________/______________.**

FOR MEDICAL RECORDS ONLY:
I understand the information disclosed may include data not created by Project Quest, but is part of my medical records, and related to the purpose of this authorization. This information may include lab reports, radiology reports, physical and/or rehabilitative therapy notes, and progress notes.

I understand the information used/disclosed/released may include HIV and HIV-related testing, substance and/or alcohol abuse and/or mental health or mental health records and/or genetic-related testing information. **My initials below authorize the inclusion of the following information**:

**_____ HIV & HIV related testing _____ Substance and/or Alcohol Abuse (SUD) _____ Genetic-related Testing _____ Mental Health Records**

I have received and understand this authorization. I also understand that the health or health-related information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, if permissible by law, and will no longer be protected under the appropriate federal and/or state regulations pertaining to the information released herein. If the information released contains drug and alcohol treatment records, the records are further protected by Federal confidentiality rules (42-CFR, Part 2). The Federal rules prohibit the further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42-CFR, Part 2. A general release of medical or other information is NOT sufficient. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

________________________________ ________________________________ __________/__________/__________
***Patient's Printed Name*** ***Patient's Signature*** ***Date Signed***

________________________________ ________________________________ __________/__________/__________
***Parent/Guardian/Authorized Persons Printed Name*** ***Parent/Guardian/Authorized Persons Signature*** ***Date Signed***

| ______________________________ | ______________________________ | ________/________/________ |
|---|---|---|
| ***Witnessed By: Printed Name*** | ***Witnessed By: Signature*** | ***Date Signed*** |