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 | info@quest-center.org

Client Legal Name: ______________________ ____________________ _____ Date of Birth: _______/_______/__________
Last First MI

Preferred Name: ______________________ ____________________ _____
(If different) Last First MI

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

[ ] To give/send medical-related information to:	Address: ____
[ ] To receive medical-related information from:	____
Provider/Entity Name:	Phone: (__________) - ___________ - ______________
____	Fax: (__________) - ___________ - ______________

Via the following method: *(Mark all that apply.)* [ ] U.S. Mail [ ] Facsmile [ ] Email [ ] Verbal [ ] Pickup [ ] Other: ______

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

I authorize the following information may be disclosed at this time or in the future: *(Initial the appropriate spaces below.)*

______**Entire Medical Record** ______All hospital records ______Transcribed hospital records ______Laboratory Reports
______Most Recent 5-year history ______Emergency/Urgent Care ______Diagnostic Imaging Reports ______Billing Info/Statements
______Pathology reports ______Medication Records ______Current Medication List

Records for this time period: _____________ to ______________ __ SUD Records __ Mental Health __ Medical __ All
Records regarding the treatment of: _______________________ __ SUD Records __ Mental Health __ Medical __ All
Records related to the MVA claim from: _________ to _________ __ SUD Records __ Mental Health __ Medical __ All

AT THIS TIME PLEASE SEND ONLY: ____
____

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 I understand that disclosures/uses/releases made prior to revoking this authorization cannot be rescinded.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 that 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

For internal use only: ____ **Request records now** ____ **Hold**