Authorization to **Receive** Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Email: _____ Phone Number: (_____) _____ - _____

I hereby authorize the following healthcare provider to disclose protected health information to Zoomcare:

Healthcare Provider: _____

Mailing Address: _____

Email Address or Fax Number: _____

Release records to:

Zoomcare, 1455 NW Irving St., Suite 600 Portland, OR, 97209 / Fax: (866) 859-8195 / Email: Health@zoomcare.com

Purpose of Release: ❑ Continuing Medical Care

Dates and Information to be released:

Dates: ❑ All Dates of Care ❑ Specific Date(s) of Care: _____

Information: ❑ All Medical Records ❑ Specific Medical Records: _____

Sensitive Information: I understand that my express consent is required to release any health care information relating to testing, diagnosing and/or treatment for HIV (AIDS virus), sexually transmitted diseases, mental health treatment, drug and/or alcohol use, and genetic testing.

By **initialing below,** I specifically authorize the disclosure of the following information and/or records:

_____ Drug/Alcohol Testing or Treatment _____ Genetic Testing _____ HIV/AIDS Testing or Treatment

_____ Mental Health Testing or Treatment _____ Sexuallly Transmitted Disease Testing or Treatment

I understand that I may revoke this authorization in writing at any time pursuant to instructions included in the Privacy Notice to Patients, except where any action already taken in reliance on this authorization has taken place.

I understand that once my protected health information has been disclosed to the recipient noted above, it may be re-disclosed and no longer protected by HIPAA (45 CFR Part 164, Subpart E).

I understand that Zoomcare may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form.

I understand that unless revoked earlier, this authorization will expire **1 year** from the date of signing, or on the following date: _____/_____/_____ whichever occurs first.

Relationship to Patient: ❑ Self ❑ Parent of Minor ❑ Legal Guardian ❑ Legal Representative

Signature: _____ Date Signed: _____/_____/_____
(Signature of patient or legal guardian)

Minor Consent: _____ Date Signed: _____/_____/_____
(Signature of minor age 12-17 if required)