



## 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, 11958 SW Garden Place, Tigard, OR 97223 / 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    \_\_\_\_\_ Sexually 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)