James J. Biemer, Jr., MD, FACP

9135 SW Barnes Rd, Suite 863, Portland, OR 97225
503.384.0316 phone 503.416.8145 fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ____ (print name) Date of Birth __________

Authorize:

____
Name of person or organization

____

____
Address

________________________ ________________________
Phone Fax

To disclose the following protected health information to:

James J. Biemer, MD
9135 SW Barnes Road, Suite 863
Portland, OR 97225
503-384-0316 phone
503-416-8145 fax

____ Complete Medical records
___ Other: please specify ____

___ To be mailed
___ To be picked up by ____
___ To be sent by fax

Reason for disclosure of protected health information: ____________________________

I do ___ do not ___ consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.

I do ___ do not ___ consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV (AIDS).

I do ___ do not ___ consent to the disclosure of substance/alcohol abuse evaluation/treatment.

I understand the following:

I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the health care provider/organization designated above.

I am entitled to receive a copy of this signed authorization.

____ ________________________
Signature of the authorizing individual Date