Authorization to Disclose My Health Care Information to
Hosseinion Family Medicine, LLC.

Patient name: _____ Date of birth:_____
Previous name: _____

I. I Authorize
(Prior Doctor's Offices – write their name/clinic here): _____
_____

To disclose the following:
☐ All health care information in my medical record
☐ Specific health care information, specify date(s):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply and initial next to all boxes checked):
☐ HIV (AIDS virus) _____ (initial here)
☐ STDs _____ (initial here)
☐ Mental health _____ (initial here)
☐ Drug or Alcohol use _____ (initial here)

Please send this health care information to:
Hosseinion Family Medicine, LLC.
1735 SE 33rd Ave.
Portland, OR 97214
Phone: 503-234-2070
Fax: 1-844-373-1869 (Preferred method)

The healthcare information requested is to be used by Hosseinion Family Medicine, LLC., for my continued healthcare.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Hosseinion Family Medicine, LLC. based upon this authorization. You may revoke this authorization by writing a letter to Hosseinion Family Medicine, LLC.

_____ _____
Patient or legally authorized individual signature — Date

_____ _____
Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative)

Last Update:__9__/05____/_2019___ This release expires one year from date of signature.