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1962 NW Kearney, Ste. 102
Portland, OR 97209
503-274-4360

Authorization to Disclose Protected Health Information

Patient name: _____ Date: _____
(DOB:)

As required by the Privacy Regulation, Dr. Gurski may not use or disclose your protected health information except as provided in our Notice of Privacy policy Practices and without your consent.

This is for the consent to release treatment progress notes, medical history and evaluation letter, phone consultation and/or labs to the patient and to other doctors involved in the patient (named above) care. The patient may revoke this at any time with a written consent.

_____ _____
Signature of patient or Patient's Representative or Guardian Date