Catherine M. Gurski, ND, LAc.
1962 NW Kearney, Suite 102
Portland, OR 97209
503-274-4360

Patient Name:______________________ Address:____
Phone: ______________________________ DOB: ____

As requested by the Privacy Regulation Dr. Gurski may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize ____
Address: ____
Street number City State Zip

To disclose my Patient Health Information to Dr. Gurski @ 503-241-4134 (Fax)
Or Please mail to the above address or release to the patient directly

By initialing the spaces below, I authorize the release of the following records, if such records exist:

_____ Entire medical record _____ Progress notes _____Laboratory reports

_____ Pathology reports _____ EKG _____ X-ray

_____ Operative reports _____ Other, Please specify ______________________________

This authorization expires 180 days from the sign date. I understand that the information above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have a right to:

1. Revoke the authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Receive a copy of this authorization.
5. Refuse to sign this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____

Signature of Patient **Date**