HIPAA Release of Information Authorization

Patient Information

Last Name: _____ **First Name:** _____ **DOB:** _____

Purpose of Authorization
I hereby authorize Frederick C. Littlejohn, M.D., and his staff to discuss, review, and disclose my protected health information (PHI) with the individuals designated below for purposes including, but not limited to, consultation, coordination of care, and treatment planning.

Authorized Individuals
I authorize my healthcare provider and designated staff members to share my PHI with the following individuals (or their agents) of my choosing:

- **Name:** _____

  Relationship to Patient: _____

- **Name:** _____

  Relationship to Patient: _____

Scope of Information to be Disclosed
This authorization covers all aspects of my PHI that may be relevant to the purposes described above, including:

- Medical history
- Diagnosis and treatment information
- Laboratory and imaging results
- Medication information
- Any other information used in the provision of care

Method of Disclosure
I understand that this information may be disclosed verbally, in writing, or electronically, and once disclosed it may be subject to re-disclosure by the recipient, potentially without further protection.

Expiration of Authorization
This authorization will expire on the following date or event:

- **Expiration Date/Event:** _____
  If no date or event is specified, this authorization shall remain in effect until I revoke it in writing, except to the extent that action has already been taken in reliance on it.

Revocation of Authorization
I understand that I may revoke this authorization at any time by submitting a written revocation to Portland Pain Solutions. I also understand that any revocation will not apply to information already released in reliance on this authorization.

Acknowledgment and Signature
I have read and understand the above information. I understand that I am not required to sign this authorization as a condition of receiving treatment, and that I may revoke my authorization at any time. By signing below, I authorize the disclosure of my PHI as described herein.

- **Patient/Representative Signature:** _____
- **Printed Name:** _____
- **Date:** _____

If signed by a personal representative (check one):
☐ I attest that I am the legal guardian or have power of attorney for the patient.
☐ I attest that the patient is unable to sign due to incapacity and I have legal authority to act on their behalf.