Authorization to Use or Disclose Protected Health Information

Patient Name: ____

Date of Birth:_____________________

Previous
name(s):____

Active Recovery TMS, LLC and TMS Physician Services, PC may use or disclose the following health care information (check all that apply):

__ All health care information in my medical record
__ Health care information in my medical record related to the following treatment or condition:
____
__ Health care information in my medical record for the date(s):
____
__ Other (ex. Billing, etc.)—specify date(s):
____

Uses and Disclosures Requiring Specfic Authorization:
Active Recovery TMS/TMS Physician Services may use or disclose health care information regarding testing diagnosis and treatment for (check all that apply):

___HIV/AIDS

___Mental Health or Illness

___Reproductive Care (minors only)

___Sexually transmitted Diseases

___Drug and/or Alcohol Abuse

Minors: A minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14

and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 or older), and mental health or illness (if age 13 or older).

I give permission for my health care information as indicated above to be disclosed to:

Name: ____

Address:____

____

Reason for this authorization to use or disclose my health information:

____

____

Your Rights:

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign this form to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Active Recovery, TMS/TMS Physician Services in reliance on this authorization before it receives my written revocation. I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   a. Fill out a revocation form which is available upon request at Active Recovery TMS or
   b. Write a letter to Active Recovery TMS, LLC at 2340 NW Thurman Street Suite 202 Portland, OR 97210.

Protection after Disclosure: I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

____

Patient or legally authorized individual's signature   Date   Time

____

Printed name (if signed on behalf of the patient)   Relationship (parent, legal guardian, etc.)

____

Minor patient's signature, if applicable | Date | Time