503.352.0240 | Fax 971.279.5635
www.nhws.us

NEW HORIZONS WELLNESS SERVICES, LLC
Empowered from Within

13333 SW 68th Parkway, Suite 020
Tigard, OR 97223

Authorization To Use And Disclose Protected Health Information

I hereby authorize New Horizons Wellness Services to use and disclose and/or receive specific health information described below regarding:

Patient Name: _____ Date of Birth: _____

To/From: _____ (Name of recipient)

Address:_____ City/State: _____

Zip Code: _____ Phone#: _____ Fax#:_____

for the purpose of: ☐ Continuation of Care/Treatment ☐ Diagnostic/Evaluation

☐ Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

Entire Medical Chart	Entire Mental Health Chart
Medical Testing Information	Mental Health Testing Information
Medical Treatment Information (summary)	Mental Health Treatment Information (summary)
Academic Records	

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to **Patient Services Manager** at New Horizons Wellness Services, LLC ~ 13333 SW 68th Parkway, Suite 020, Tigard, OR 97223 and state that you are revoking this authorization. Unless revoked earlier, this consent will expire **90** days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. I have read this information and I understand it. Unless revoked, this authorization expires _____ (insert either applicable date or event).

Responsible Party Signature:_____ Date: _____