PACIFIC NORTHWEST
OCCUPATIONAL THERAPY LLC

Improving your quality of life.

AUTHORIZATION
TO DISCLOSE HEALTH INFORMATION

I authorize ____ to disclose a copy of the specific health and medical information described below regarding:

_______________________________   _______________   _________________________
Name of Client   Date of Birth   SS#

I understand that my health care and payment of that health care cannot be conditioned to my Authorization. I understand that this information will be used to help the therapists evaluate and develop an individualized and comprehensive therapy program.

I specifically authorize the use and disclosure of the following:

_____ Emergency and Urgent Care Records   _____ Therapy Reports (OT,PT,SLP)

_____Hospital Inpatient Records   _____ Radiology/Diagnostic Reports

_____ Clinic/Outpatient Records   _____ Consultation/3rd Party Records

_____Mental Health Records   _____ Other:_________________________

Send to: Pacific Northwest Occupational Therapy, LLC
1396 Duane Street   Astoria, OR 97103
Phone: 503-325-8115   Fax: 503-325-8212

This Authorization will expire **1 year** from the date of signing. You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke Authorization, we will no longer use or disclose information about you, but we cannot take back any uses or disclosures already made with your permission.

I have reviewed and understand this Authorization:

By:____   Date:______________

If patient representative, describe authority:____