



150 Kenneth Ford Drive, Roseburg, OR 97470 Phone: 541-672-9596 Fax: 844-870-1183

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION:** Completion of this document authorizes the disclosure and/or use of health information. Please be sure to provide all information requested. Failure to do so may invalidate this authorization. This authorization expires 12 months after it is signed.

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure, or to allow another healthcare provider, or health plan, to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. In the course of providing services or treatment to you, we may need to re-disclose your health information to another healthcare provider or health plan; re-disclosed health information is not protected by this Authorization or the HIPAA rules or regulations.
3. You may inspect a copy of the protected health information to be used or disclosed;
4. You may refuse to sign this Authorization; and
5. We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Previous Names: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**I request and authorize:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Purpose: \_\_\_\_\_

**To:**

Name: Aviva Health  
 Address: 150 Kenneth Ford Drive, Roseburg, OR 97470  
 Phone Number: 541-672-9596 Fax Number: 844-870-1183

**Consent is required for any disclosure of records to be sent regarding the sensitive information below. Initials required:**

- \_\_\_ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
- \_\_\_ By initialing here, I specifically consent to the disclosure of my mental health information.
- \_\_\_ By initialing here, I specifically consent to the disclosure of any and all STI/STD information.
- \_\_\_ By initialing here, I specifically consent to the disclosure of my genetic testing information.
- \_\_\_ By initialing here, I specifically consent to the disclosure of my drug and alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

By initialing the spaces above, I specifically authorize the release of the following:

\_\_\_ **All Records** – sensitive protected information: HIV/AIDS, Mental Health, Genetic Testing, and Drug/Alcohol Use.  
 If this area is not initialed above, we must read through documentation and redact any pertinent information. We will only redact documents back one year.

**OR:**

\_\_\_ Clinician Office Notes                      \_\_\_ Laboratory Reports                      \_\_\_ Dental Notes  
 \_\_\_ Diagnostic Imaging Reports                      \_\_\_ Pathology Report                      \_\_\_ Vaccine Records

\_\_\_ Other (be specific) \_\_\_\_\_

Patient or Legal Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

