DR. HIDENAO KIMURA
19365 SW 65TH AVE. SUITE 111
TUALATIN, OR 97062
PHONE: 503-612-1181
FAX: 503-612-1182

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, (Name)________________________________ DOB: ______________________

Patient Address:

____

Authorize:

(Name of Physician)___________________ (Phone)_______________(FAX)______________

To provide Dr. Hidenao Kimura, MD 19365 SW 65th Ave. Suite 111 Tualatin, OR 97062

The information (**two years worth**) to be released:

____

Purpose or need for information requested:

Continue Care _______ Insurance _______ Legal _______Transfer _______ Personal ______

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by witten, dated, and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

Signature ______________________ Relationship ____________ Date________________

A copy of this authorization has been _______ accepted _______ rejected by the patient/representative.

A photocopy of this authorization will be considered valid unless otherwise specified.

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Office use only: