AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize ____

(Name of Facility)

To use and disclose a copy of the specific health and medical information described below regarding

____

(Name of Patient) *DOB* *Record #*

Consisting of ( ) CD ( ) REPORTS For Dates of Service ______________________________

To: ____

(Name and address of recipient or class of recipients)

____

For the purpose of: ____

(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

(1) Your health care treatment and payment for that treatment will not be conditioned upon receipt of this signed authorization unless your health care treatment is for the purpose of (a) research; or (b) creating health information about you for disclosure to a third party.

You have the right to revoke this authorization at any time, provided that you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization. However, a revocation is not effective to the extent that any person or entity has already acted in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke this authorization, please send a written statement attention Medical Records at 881 O'Hare Parkway, Medford, OR 97504 that identifies the date you signed this authorization, the recipient of the information identified in this authorization, and state that you are revoking this authorization.

This Authorization will expire on the earlier of _____________ (Date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand the authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: ____ Date: __________________

(Patient)

-OR-

By: ____ Date: __________________

(Patient Representative)

Description of Representative's Authority: ____