Note to Our Patients: Federal and state law allows us to use and disclose information about you for purposes of treatment, billing and receiving payment, and routine health care operations. In order to use or disclose information about you for any other purpose, we need your specific authorization on the form set out below. The "Notice of Patient Privacy Practices" which we provided to you explains how this clinic uses and discloses information. You should read that Notice carefully before signing this authorization form.

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION
(Original for Medical Provider and copy to Patient)

I hereby authorize _____ to use and disclose specific health

and medical information about _____ _____
(print name of patient) (Date of Birth)

The information to be used or disclosed consists of (Initial the type of information):

_____My entire medical record
_____Records of my physical therapy referral, diagnosis and treatment
_____Billing statements
_____Other (describe) _____

If the information is 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.

_____HIV / AIDS information
_____Mental Health information
_____Genetic testing information
_____Drug / alcohol diagnosis, treatment, or referral information

I authorize this information to be disclosed to:

_____
(Name and address of recipient or recipients)

For the following purpose:

_____
(Describe the purpose of disclosure or indicate that the disclosure is at the request of the individual)

Your health care, payment for that health care, enrollment in a health plan or eligibility for health benefits does not depend on you signing this authorization unless the health care or treatment is for the purpose of: 1) Creating health information about you specifically for disclosure to a third party; or 2) research.

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*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the HIPAA Privacy Official at 2780 E. Barnett Road Suite 130 Medford, OR 97504 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and states that you are revoking this Authorization.

This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or at the end of the period reasonably needed to complete the authorized disclosure.

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

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____