ADVANCED CARE HEALTH SYSTEMS

1463 E McAndrews Rd Suite B
Medford, OR 97504
Phone: (541) 414-0481
Fax: (541) 414-0482

Authorization to Use and Disclose Health Information

I hereby authorize (previous healthcare provider): _____

Name of disclosing party _____

Address _____

City, State Zip _____

Phone _____ Fax _____

To disclose to: _____

Name of Recipient _____

Address _____

City, State Zip _____

Phone _____ Fax _____

Records and information pertaining to:

Patient name (list other names used) _____ SS# _____ Date of Birth _____

Address _____ Phone number _____

For the purpose of:_____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the above date of signature unless a different date is specified here_____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box, initial to specify which type of information is to be disclosed, and then sign and date.

☐ Medical information _____ (initials) ☐ Psychiatric information _____ (initials)

☐ Drug/Alcohol Information _____ (initials) ☐ Results of HIV Test _____ (initials)

☐ Genetic Records _____ (initials)

Signature:_____Date:_____

A copy of this authorization is as valid as the original.