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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize:

to disclose to:

Name of Disclosing Party

Wellspring Family Practice

Name of Recipient

Address

1716 Williams Hwy

Address

City State Zip

Grants Pass, OR 97527

City State Zip

Records and information pertaining to:

Patient name:

Social Security Number:

Date of Birth:

Address:

Telephone number:

For the purpose of: _____

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

Revocation: This authorization is also 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.

Redisclosure: 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 and/or sign to specify which type of information is to be disclosed.

- Medical Information** _____ Initial
- Psychiatric Information** _____ Initial
- Drug/Alcohol Information** _____ Initial
- Results of HIV Test** _____ Initial
- Genetic Records** _____ Initial

A copy of this authorization is a valid as the original. Patient has a right to a copy of this authorization

Signature

Date