Jon E. L. Ermshar, MD | **1716 Williams Hwy** | **Brett Rasmussen, PA-C**
Grants Pass, OR. 97527
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Fax 541-474-4527

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize (Previous Dr):

_____
Name of Disclosing Party

_____
Address

_____
City State Zip

to disclose to:

Wellspring Family Practice
Name of Recipient

1716 Williams Hwy
Address

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: _____Transfer of care_____

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**