AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, ______________________________ hereby authorize:
Patient Name DOB

____
Name of health care provider

____
Fax Number

To disclose to:

Bear Valley Medical Clinic
1690 NE Lynda Lane
Grants Pass, OR 97526

Records and information for the past two (2) years pertaining to:

____
Patient name (list other names used)

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 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.

- ☐ Medical Information ______ (Initials)
- ☐ Psychiatric Information ______ (Initials)
- ☐ Drug/Alcohol Information ______ (Initials)
- ☐ Results of an HIV Test ______ (Initials)
- ☐ Genetic Records ______ (Initials)
- ☐ Other Health Information ______ (Initials and specify below)
- ☐ Specify the records to be disclosed: ______________________________

The recipient may use the health information authorized on this form for the purpose of transferring care.

____
Signature Date If signed by other than patient, indicate relationship

1690 NE Lynda Lane, Grants Pass, OR 97526
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BearValleyMedicalClinic.com