AUTHORIZATION FOR BEAR VALLEY TO RELEASE HEALTH INFORMATION

I, _____ hereby authorize:
Patient Name DOB

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

To disclose to:

_____
Name of health care provider

_____
Fax Number

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