



ADVANCED HEALTH
& WELLNESS

Authorization to Use and Disclose Health Information

I hereby authorize (previous healthcare provider):

To disclose to:

Name of disclosing party

Name of Recipient

Address

Address

City, State Zip

City, State Zip

Phone

Fax

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

Medical Information

(Initials)

Psychiatric Information

Drug/Alcohol Information

(initials)

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

☐☐

(initials)

3132 Medford OR
97504**Phone:** (541)
414-0481

☐

☐ Genetic Records

☐ Results of HIV Test

_____ (initials)

Signature:

Date: