RELEASE OF INFORMATION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____
(Name and address of person/entity disclosing information) to use and disclose a copy of the specific health information described below regarding:

_____

Name of Individual Date of Birth

consisting of medical record including lab and imaging to:

Quality Life Family Practice, LLC
1201 NE 7th Street, Suite E
Grants Pass, Oregon 97526

For the purpose of continuing health care.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Genetic Testing Information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information and drug/alcohol diagnosis, treatment or referral information.

_____

Signature of Individual or Personal Representative Date

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information describe above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, send a written statement to:

Quality Life Family Practice, LLC
1201 NE 7th Street, Suite E
Grants Pass, Oregon 97526

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires: _____ (Insert either applicable date or event).

_____

Signature of Individual or Personal Representative Date

Description of personal representative's authority: