165 S 5th St., Suite A
Coos Bay, OR 97420
Phone: 541-267-7086
Toll Free: 1-800-526-3057

Western Mercantile Agency

Dear Consumer,

Your consent must be given before we can communicate with anyone other than yourself. If you wish for us to discuss your account with anyone other than yourself, review and fill out the attached Medical Authorization to Release Protected Health Information. Please date, sign, and return it to our agency at once.

Very Truly Yours,

Western Mercantile Agency, Inc.

This is an attempt to collect a debt by a debt collector and any information obtained will be used for that purpose.

MEDICAL AUTHORIZATION TO RELEASE

PROTECTED HEALTH INFORMATION

I, _____ (DOB _____),
authorize Western Mercantile Agency, Inc., and its employees, officers, subsidiaries, and attorneys to disclose my health information as identified below to

(name) _____

(address) _____
for the purpose of assisting me in Western Mercantile Agency, Inc.'s attempt to collect a debt.

By initialing on the lines below, I specifically authorize the disclosure of the following health information to #{ConsentName}:

_____ Medical records related to the debt(s) which is/are being collected by Western Mercantile Agency, Inc.

_____ Medical billing records related to the debt(s) which is/are being collected by Western Mercantile Agency, Inc.

If the information to be disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information may apply. I agree that the following categories must be initialed to be included in this authorization to release information.

_____ HIV/AIDS related information/records

_____ Mental health information/records

_____ Genetic testing information/records

_____ Drug & alcohol diagnosis, treatment, or referral information. Federal law prohibits the re-disclosure of this information. Federal law requires that a description of the kind of information and amount of information to be release be specifically stated. The information to be released is:

_____

This authorization does not apply to psychotherapy notes.

Except to the extent that action has been taken in reliance of this medical authorization, I understand that I may revoke this medical authorization at any time by giving written

notice to this provider. Unless revoked earlier, this authorization will terminate on: [insert date or event causing termination of authorization] _____

_____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information disclosed under this authorization.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I understand that the person(s) I am authorizing to disclose my information may receive compensation for doing so.

_____ Date: _____

Name

[A copy of this signed form will be provided to the individual and/or the individual's legal representative.]