Family Tree Medical Clinic

2508 NW Medical Park Drive, Roseburg, OR 97471
Phone: (541) 673-5225 Fax: (541) 229-4777
Dr. Sarah Agsten, DO and Dr. Heidi Beery, MD

Protected Health Information Disclosure Authorization and Consent

I, _____ (*name of patient*) _____ (*date of birth*), authorize Sarah L. Agsten, D.O. LLC, DBA Family Tree Medical Clinic to use and disclose my medical information described below to the following person(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check this box if you do not wish to authorize any contacts ☐

The health information to be used and disclosed includes the information specifically authorized below as well as all other information in my health records relevant to scheduling/discussing appointments or referrals; disclosing lab and/or imaging results.

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.

____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
____ By initialing here, I specifically consent to the disclosure of my mental health information.
____ By initialing here, I specifically consent to the disclosure of my genetic testing information.
____ By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date:_____
(signature of patient or patient's personal representative)

Authority: _____
(if you are signing as personal representative, please add a description of your authority to act for the patient)

Unless revoked in writing, this Authorization expires one year from the date above unless requested otherwise by your initials below in the appropriate section:

❒ 5 Years ( ) ❒ Never ( ) ❒ Other Date: _____ ( )

Please note:
You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization.