MID-VALLEY GASTROENTEROLOGY
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize: _____
(Name of physician/physician group disclosing information)

_____

to disclose a copy of the specific health and medical information described below regarding:

_____ _____
(Name of patient) *(Date of Birth)*

consisting of: _____

_____
(Describe information to be disclosed)

to: _____

_____
(Name and address of recipient)

for the purpose of: _____
(Describe <u>each</u> purpose of disclosure or state "at the request of the individual".

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 may be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Alcohol/chemical dependency diagnosis, treatment, or referral information
_____ Sexually transmitted disease information
_____ Genetic testing information

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of creating health information about you to be disclosed to a third party.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Privacy Officer, Mid-Valley Gastroenterology, 3521 NW Samaritan Dr., Suite 101, Corvallis, OR 97330 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on _____ (date) or in 180 days from the date of signing, whichever comes first.

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.

_____ _____
Patient or legal representative (describe representative's authority) Date