AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Willamette Valley Psychiatric Medicine, LLC
132 E Broadway, Suite 201
Eugene, OR 97401
Phone 541-344-5363 Fax 541-344-5369

I authorize
□ Timothy Mitchell, MD □ Elaine Mitchell, DO □ Karen Crocker-Wensel, MD

to □ receive from □ disclose to

_____

a copy of the specific health and medical information initialed below for the purpose

of medical treatment regarding _____, _____.
Name of patient (please print) Date of birth

By INITIALING the space(s) below, I am authorizing release of medical information for these conditions (if you do not initial the following space, WVPM will not release/request any information regarding that condition):

_____ Entire Medical Record (excluding below unless initialed)
_____ Medical records developed between _____ to _____
_____ Other _____

Specific release of the following information will be included if INITIALED:

_____ Mental Health	**_____ HIV/AIDS**
_____ Chemical Dependency	**_____ Genetic Testing**

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and this consent automatically expires at the end of treatment. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

_____ _____
Signature of Patient or Guardian **Today's Date**