1650 SW 45th Place
Corvallis, OR 97333

fax: 541.758.1030
phone: 541.757.8068

Physician Release of Information

Client Name: **Date of birth:**

Information to Be Used or Disclosed

Information to be obtained under this disclosure agreement: Progress Notes, Assessments, Tx Plans, Medications, Formulations.

Purposes of Disclosure

Information listed above will be disclosed for the following: Mental Health services and coordination.
Other:

Physician Authorized to Use or Disclose Information

Information listed above will be used or disclosed to:
Name of person/organization:

Address/Phone/Fax:

Therapist to Whom Information may be Disclosed

Information described above may be disclosed to:

Old Mill Center for Children and Families
1650 SW 45th Pl., Corvallis, OR 97333
Phone: (541) 757-8068 Fax: (541) 758-1030

Expiration Date of Authorization

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Old mill

Potential for Redisclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations..

Rights of the individual

You may inspect or request a copy (in writing) of information that is used or disclosed under this authorization
You may refuse to sign this authorization.

Name of Patient:_______________________________________ Date:___________________________

Signature of Patient Representative _______________________ Relationship: :____________________
(Required if the patient is a minor or an adult who is unable to sign this.)

Old Mill Center Representative __________________________