Old Mill Center for Children and Families
1650 SW 45th Place
Corvallis OR 97333-1768
PH: (541) 757-8068 Fax: (541) 758-1030
www.oldmillcenter.org

Physician Release of Information

Client Name:

Date of Birth:

Information to Be Used or Disclosed
Information to be obtained under this authorization includes:

Individual Service Notes, Assessments, Individualized Service-Support Plans, Medications, Formulations.

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:

Mental Health Services and Coordination.

Physician Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

_____
Name of Doctor:

_____
Address/Phone/Fax

Therapist or Organization to Whom Information may be Disclosed
Information described above may be disclosed to:

Old Mill Center for Children and Families
Name of person/organization

Address: 1650 SW 45th Pl., Corvallis, OR 97333 Phone: (541)757-8068 Fax: (541)758-1030

Expiration of Authorization

This authorization is effective for a year from the date signed (unless revoked or terminated by the patient, or legal guardian.)

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Old Mill Center.

Potential for Re-disclosure

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. Refusal to sign this authorization will not impact services to be delivered.

Client (Please Print): _____ Date: _____

Client Signature: _____

Legal Guardian (Please Print): _____ Date: _____

Legal Guardian Signature: _____