White Bird Medical Clinic

1400 Mill Street Eugene, Oregon 97401
phone: 541.484.4800 fax: 541.344.8351

I authorize **White Bird Medical Clinic** to use and disclose a copy of specific health information described below regarding:

____
(Client name and Date of Birth)

To: ____
(Name, address, phone, and fax of agency, institution, or individual to whom the disclosure is made)

Purpose of disclosure: ____

Information to be disclosed: ____

* 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**.

______ HIV/AIDS information
______ Mental Health information
______ Genetic testing information
______ Drug/alcohol diagnosis, treatment, or referral information.

Provider Information- If we are requesting this Authorization from you for your own use and disclosure or to allow another health care provider or health plan to disclose information to us:

A. We cannot condition treatment, payment, enrollment, or eligibility for benefits on the receipt of this signed authorization;
B. You may refuse to sign this Authorization

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes describes in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to the Office Staff at White Bird Medical, 1400 Mill St., Eugene, OR, 97401, and state that you are revoking this authorization.

Signature- I understand that the information used or disclosed pursuant to this authorization may be subjected to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alchohol diagnosis, treatment or referral information.
I have read this authorization and I understand it. Unless revoked, this authorization expires on year from the date of signing.

____ ____________________
(Signature of Client) (Date)

Description of personal representative's authority: ____

* White Bird Medical Clinic is a non-profit organization that does not have the resources to pay for copies of records. For this reason, we ask that you waive any customary fees for copies. We thank you in advance for your assistance. Please contact us if you have any questions concerning this request.