AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: _____
(Name of Previous Health Care Provider)

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

regarding: _____
(Name of Patient) (Date of Birth)

To: **Lisa Callahan, CPNP-PC**
Lori Simmons FNP-C
1601 NE 6th St
Grants Pass, OR 97526
Phone (541) 472-0021
Fax (541) 476-4003

for the purpose of _____
(Such as "transfer of medical care")

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**

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

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 described 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 our privacy officer. Unless revoked earlier or otherwise indicated, this Authorization shall remain in effect for the duration of the Trustor's trust.

SIGNATURE: I have read this authorization and I understand it.

By:_____ Date:_____
(Patient)

By:_____ Date:_____
(Patient Representative)
Description of Representative's Authority_____