Aspire Mental Health and Wellness LLC
713 E Jackson St, Medford, OR 97504
Phone: 541-414-4966
Fax: 541-816-4600

Authorization to Use/Disclose Protected Health Information

_____ _____
Patient Name DOB

I hereby authorize the use or disclosure of my personal health information as described below.

INFORMATION TO BE RELEASED

TO: _____ FROM: _____
Name Name

_____ _____
Address Address

_____ _____

INFORMATION TO BE RELEASED (check one):

____ The most recent two years of pertinent information (chart notes, labs, x-rays, and diagnostic tests)
____ All medical records
____ Specific information (please specify):

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE (check one):

____ Doctor ____ Insurance ____ Personal ____ Attorney ____ Other (specify): _____

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment) **I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released.** I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____
Patient or Representative Signature Date

_____
Relationship to patient