CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Use and Disclosure of Your Health Information Your protected health information will be used by Bruce E. Perry MD or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this practice.

Notice of Privacy Practices You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information You may request a restriction on the use or disclosure of your protected health information. Bruce E. Perry MD may or may not agree to restrict the use or disclosure of your protected health information. If Bruce E. Perry MD agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

Revocation of Consent You may revoke the consent to the use and disclosure of your protected health information. You must revoke this request in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices Bruce E. Perry MD reserves the right to modify the privacy practices outlined in this notice.

I have reviewed this consent form and give permission to Bruce E. Perry MD to use and disclose my health information in accordance with it. I also acknowledge I have been given a copy of Dr. Perry's Privacy Practices.

_____

Name of Patient (please print)

_____ _____

Patient Signature Date

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize Bruce E. Perry, MD to use and disclose a copy of the specific health information described below regarding _____ (patient's name) for the purpose of _____.

The specific information to be disclosed is _____.

The information may be released to the following recipient: _____

_____

_____

_____

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 space next to the type of information listed below:

_____ HIV / AIDS information

_____ Mental health information

_____ Genetic testing information

_____ Sexually transmitted disease information

_____ Alcohol/chemical dependency 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 law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment, or referral information and specifically requires my authorization prior to redisclosure.

NOTE TO PATIENT

You do not need to sign this authorization. Refusal to sign the authorization will not effect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research-related treatment and the authorization is necessary to participate in the research study.

HOW TO REVOKE 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 described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement revoking this authorization to: Bruce E. Perry, MD
1619 NW Hawthorne Ave., #210
Grants Pass, OR 97526

SIGNATURE

I have read this authorization and I understand it.

Unless revoked, this authorization expires on this date or event: _____.

_____ _____

Signature of patient or personal representative Date

_____

Description of personal representative's authority