

**CONSENT FOR USE AND DISCLOSURE OF  
Personal Health Information**

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact:

Our Office Manager at (541) 476-7781.

**Patient's Consent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I, \_\_\_\_\_, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient's Revocation**

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature to revoke authorization: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_