

**OLD MILL CENTER FOR CHILDREN AND FAMILIES**  
4515 SW Country Club Drive  
Corvallis, OR 97333  
(541) 757-8068 (541) 758-1030 Fax



# Physician Release of Information

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Information to Be Used or Disclosed

Information to be obtained under this authorization includes:

Progress Notes, Assessments, Tx plans, Medications, Formulations. \_\_\_\_\_

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## Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

Mental health services and coordination \_\_\_\_\_

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## Physician Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

\_\_\_\_\_  
Name of person/organization

\_\_\_\_\_  
Address/Phone/Fax

## Therapist to Whom Information may be Disclosed

Information described above may be disclosed to:

\_\_\_\_\_  
Old Mill Center for Children and Families

\_\_\_\_\_  
Name of person/organization

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\_\_\_\_\_  
Address/Phone/Fax

## Expiration Date of Authorization

This authorization is effective through \_\_\_/\_\_\_/\_\_\_ unless revoked or terminated by the patient or the patient's personal representative.

### Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Old Mill Center.

### Potential for Redisclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

### Rights of the individual

You may inspect or request a copy (in writing) of information that is used or disclosed under this authorization.

You may refuse to sign this authorization.

## Signature

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

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

(Required if the patient is a minor or an adult who is unable to sign this form)