

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



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

**Information to Be Used or Disclosed**

Information to be obtained under this authorization includes:

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**Purposes of Disclosure**

Information listed above will be disclosed for the following purposes:

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**Person Authorized to Use or Disclose Information**

Information listed above will be used or disclosed by:

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Name of person/organization

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Address/Phone/Fax

**Person to Whom Information May be Disclosed**

Information described above may be disclosed to:

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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**

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Name of Patient (Print or Type)

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Signature of Patient

Date

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Signature of Patient Representative

Relationship to Patient

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