John B. Milnes, M.S.W. Sandra L. Stradley, M.S.W.
1645 Liberty St. SE
Salem, OR 97302
(503)585-5328 (503) 588-2155 Fax (503)-588-5327

AUTHORIZATION to USE/DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____
I authorize _____ **John B. Milnes, M.S.W.** _____ **Sandra L. Stradley, M.S.W.** to:

(Initial) _____ release information to: ***(Initial)*** _____ obtain information from:

_____ _____
Name of Provider Address

Telephone: (_____)_____ Fax Number (_____)_____

Specifically, I authorize the exchange of the following confidential information by my ***Initial*:**

(Initial) _____ All Records in File ***(Initial)*** _____ Evaluations
(Initial) _____ Educational Records ***(Initial)***_____ Drug/Alcohol Information
(Initial) _____ Telephone Consultation ***(Initial)*** _____ Legal Records
(Initial) _____ Clinical information, excluding Psychotherapy Notes
(Initial) _____ Medical Records, limited to the following: _____
(Initial) _____ Other: _____

For the purpose of [ ] Treatment Coordination [ ] Continuity of care [ ] Insurance [ ] Legal review
[ ] Other: _____
I have reviewed and I understand this Authorization. By signing this Authorization, you are directing us to disclose your health information to another person or organization that may not have or obey the same obligations to protect privacy that we do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for unauthorized re-disclosure and loss of protection under state and federal law.

This authorization will expire 180 days from the date of signing unless revoked earlier or otherwise indicated.

_____ _____
Signature of patient or authorized representative Date

Description of Representative's Authority: _____