STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

All Protected Health Information

Authorized to Use or Disclose information
Information listed above will be used or disclosed by:
Terence H. Young, M. D. LLC
Name of person or organization
1205 Wallace Rd. NW, Salem, OR 97304
Address of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

Name/relationship of person(s) or organization PHONE

Name/relationship of person(s) or organization PHONE

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 Terence H. Young, M.D. LLC. You should contact either of the Receptionists to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Signature of Patient

Name of patient (Print or type) Date

Signature of Patient Representative

Relationship of Patient Representative to Patient