

Authorization to Disclose and/or Obtain Health and Dental Records

Patient Name:					
	First	Middle	Last		
Date of Birth:	SSN:				
By signing below, I a	uthorize				
☐ Ko-Kwel Wellness Center Coos Bay 630 Miluk Drive Coos Bay, Oregon 97420 Fax: 541-888-5556		2401 River l Eugene, Or	 ☐ Ko-Kwel Wellness Center Eugene2401 River Road, Ste 101Eugene, Oregon 97404Fax: 541-916-7049		
☐ To DISCLOSE my	health information to:				
☐ To OBTAIN my hea	alth information from:				
Facility and/or Entity	Name:				
Address:					
City, State, Zip Code	:				
Phone: Fax:					
The purpose of this rel		The informa	tion to be disclosed is:		
☐ Continuing Medical☐ Personal☐ Other:		Specified	ecora time period: ecify):		
By initialing the spaces HIV/AIDS Rela Mental Health Genetic Testin Drug/Alcohol E	ited information Information g Information Diagnosis, Treatment	or Referral Informati		ervices or reimbursement for	
ices. The only circumstance when refut th information to someone else and the authorization, the information describ	usal to sign means you will no ne authorization is necessary ned above may no longer be reliance on the authorization	of receive health care service to make that disclosure. You used or disclosed for the pu n, or the authorization was o	is is if the health care services are solely u may revoke this authorization in writing rposes described in this written authorization btained as a condition of obtaining insu	y for the purpose of providing ng at any time. If you revoke zation. The only exception is	
signature of Patient:			Date:		
			Date:		