



**DOUGLAS COUNTY
VETERANS SERVICE OFFICE**

*1036 SE Douglas Room 105 B
County Courthouse
Roseburg, OR 97470
(541) 440-4219 Fax (541) 440-6166*

**AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

Name of Veteran

I hereby authorize the **Douglas County Veterans Service Office** to use and disclose the following health information described below regarding the above client, which consists of:

- Any information to fully adjudicate my claim
- Any necessary protected health information
- Any or all protected health information concerning the above-referenced client

For the purpose of preparation, presentation and prosecution of my claim.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information

___ Mental Health information

___ Genetic Testing information

___ Drug/Alcohol diagnosis or treatment

Duration: I understand that I may revoke this consent at any time by notifying the Douglas County Veteran Service Office in writing, except to the extent that it has already been acted upon prior to my revocation. This consent shall remain in effect until revoked.

Restrictions: Release or transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information.

- A copy of the Notice of Privacy Practices is available upon request.

Signature of Client or Personal Representative

Date