PUBLIC HEALTH DIVISION
CENTER FOR HEALTH PROTECTION
Oregon Psilocybin Services
http://oregon.gov/psilocybin

AUTHORIZATION TO DISCLOSE PERSONAL IDENTIFIABLE INFORMATION

This form must be used to authorize disclosure of personal identifiable information. Licensees may not use their own authorization forms.

By filling out and signing this form, I am agreeing to permit [*name of service center or facilitator*]_____ to use or disclose certain personal identifiable information about me and the services that have been provided to me by [*name of service center or facilitator*] _____.

This authorization is not valid unless all fields have been completed.

I, _____, authorize the use or disclosure of my personal identifiable information as described below:

1. [*Name of service center, facilitator, or both*]

_____ is authorized to disclose the following information about me to *[name of specific individuals and the entity they are associated with, or the name of an organization*]

2. I authorize the following information to be disclosed to the individuals or entities identified above:

3. The purpose of the use or disclosure of this information is:

4. This authorization is valid beginning _____ and expires on _____.

5. Acknowledgement.

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the individuals or entities that are allowed to receive it, without any further consent from me.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke the authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Printed Name _____

Signature _____

Date _____