Hello

Welcome to South Hilyard Clinic! We look forward to caring for you!

As your primary care home, we will:

✓ Better coordinate your care to help get you the services you need, when you need them.
✓ Listen to your concerns and answer your questions.
✓ Help you play an active role in your health.

A Patient-Centered Primary Care Home (PCPCH) is a health clinic that is recognized for their commitment to patient-centered care. Just as it sounds, patient-centered care is all about you and your health!

We will make prevention and wellness a top priority. If you have a special health concern or condition, your health care team will help connect you with other health professionals to get you the care you need. Your team is led by your primary care provider (find your team below).

Team: Terry Copperman, MD
Medical Assistant: Christina
Reception: Leona, Jordan
Referral Coordinator: Lori
Billing: Dallas

Team: Meg Hamilton, FNP
Medical Assistant: Claudia
Reception: Leona, Jordan
Referral Coordinator: Lori
Billing: Dallas

Team: Jan Lintz, PA-C
Medical Assistant: Saleshni
Reception: Leona, Jordan
Referral Coordinator: Lori
Billing: Dallas

Please review the entire packet and complete the enclosed forms. Remember to bring your current insurance card, a form of payment, and an up to date list of medications and supplements.

If you have questions regarding your appointment or this packet, please contact us at 541-687-8581. We invite you to visit our website at www.southhilyard.com, where you can find more information about our providers and services.

We look forward to meeting you at your upcoming appointment scheduled on__________________.

For your good health,

South Hilyard Clinic
Clinic hours are from 8:30 am - 5:00 pm, we also hold occasional Saturday clinics. Please contact the office or visit our website to inquire about specific dates.

If you are having a life threatening emergency, please call 911. If you are experiencing a non-life threatening medical issue and need to contact the clinic after hours please call the office number at 541-687-8581 and our answering service will connect you to the on-call physician.

Please contact your pharmacy for all prescription refills that do not have to be picked up in the office. If your Rx bottle indicates you are out of refills the pharmacy will send us the request to authorize additional refills. Please allow 24-48 hours for your refill to be processed.

It is necessary for our medical staff to prioritize call backs by addressing the most medically necessary calls first. We receive a lot of phone calls daily and try our best to answer them in a timely manner. If you do not receive a call back in what you feel is a reasonable amount of time, please call again. The providers make most of their calls during lunch and after hours.

We use an automated system to remind you of your appointments, and to inform you when a prescription has been sent to the pharmacy. A voice message will be sent as well as a text message reminder. If you answer your phone you can confirm your appointment by staying on the line. If you need to reschedule we ask you call the office, and we would be happy to assist you.

Onsite or telephonic interpretation services are available upon request.

We encourage you to visit our website at www.southhilyard.com for more details regarding our office policies.
Financial Policy Acknowledgement

In the interest of a good health care practice, it is desirable to establish an office and credit policy to avoid misunderstandings. Our primary responsibility is to help our patients enjoy a positive experience and provide excellent health care.

- Patients will need to provide our office with their social security number and health insurance card (if applicable) unless the total charge is paid in cash at time of service. Treatment may be postponed if patient does not furnish the items above.

- All accounts balances are due at the time of the visit (this includes co-pay, deductible, or percentage not paid by insurance). A 20% discount is extended to patients with no insurance coverage, but only applies when the visit is paid in full on the same day of the service. There will be a fee of $10.00 for those who are unable to pay their co-pay at the time of service.

- Insurance is billed as a courtesy to our patients. It is the responsibility of the patient to verify demographic and insurance information at every visit, and to inform the clinic of any changes. Any questions or disputes about the insurance policy, for example what treatment is covered and the patients out of pocket expense, will need to be resolved by the patient directly with their insurance carrier. Ultimately, the patient is responsible for the timely payment of their account.

- A fee of $15.00 will be charged if payment is not made by the due date listed on patient statement. There will be a charge of $25.00 for any NSF returned check.

- There will be a $20.00 charge for a missed appointment or canceling with less than 24 hours notice. On the third instance a $50.00 charge will be assessed, and may result in scheduling limitations (scheduling the day you wish to be seen only) or discharge from the practice. The initial consultation appointment missed or NOT canceled with 24 hour notice may result in the inability to reschedule or establish care at our facility. As a courtesy the clinic generally attempts a call to the patient before the appointment time to confirm, but is the sole responsibility of the patient to be aware of their appointment date and time.

I have read the South Hilyard Clinic and credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a collection agency and I may be charged a collection fee of up to $75.00. Also, if it becomes necessary to effect collections on any amount owed on this or subsequent visits; the undersigned agrees to pay for all costs and expenses, including attorney fees.

_________________________________________  ____________________________
Signature                                              Date

___________________________________________________
Print Name
South Hilyard Medical Clinic
Family & General Practice

Patient Intake Form

Date: __/__/____ Primary Care Provider: __________________________

Patient Information

Patient Name: __________________________

Last First Middle Initial

D.O.B: ________________ Sex: Male ☐ Female ☐ Transgender ☐ Social Security#: ________________

Mailing Address: __________________________ City: ____________ State: __________ Zip: __________

Address (if different from mailing address) __________________________

Home Phone (land line only): (____) __________________________ Ok to leave message? ☐

Cell Phone: (____) __________________________ Ok to leave message? ☐

Marital Status: Single Married Divorced Widow Partner

Emergency Contact: __________________________ __________________________ (____) __________

Name Relationship Phone Number

Email Address: __________________________

Are you web enabled for South Hilyard’s secure patient portal? Yes ☐ No ☐

If you are not web enabled and would like to be, provide us with your email, check the box and we will email you a user name and temporary password. The patient portal allows you to view your health information safely and securely in your own home.

Yes, I would like to be web enabled ☐

Race: White Hispanic Asian African American or Black American Indian or Alaska Native Native Hawaiian

Other Race Other Pacific Islander Unreported *(please select one only)

Ethnicity: Non-Hispanic or Latino Hispanic or Latino Unreported *(please select one only)

Primary Language: __________________________ Interpreter required? Yes ☐ No ☐

Preferred Pharmacy/Location: __________________________

Mail Order: __________________________

Other than yourself, do you wish to give consent to share medical information with an individual(s)? If naming a person below, please be aware it is the sole responsibility of the patient or guardian (if a minor) to inform South Hilyard Clinic if you wish to remove or change this consent in any way.

Name: __________________________
Automated appointment reminders/pharmacy notification options:

Preferred Phone number: Home (land line only) □  Cell □
Preferred Language: English □  Spanish □
Preferred Time to Call: Morning □  Afternoon □  Evening □

Insurance Information

For billing purposes, if the subscriber is someone different than yourself, please provide us with the following information regarding the Subscriber, along with a copy of your Insurance card.

Primary: Co-pay $_________  Secondary: Co-pay $_________
Insurance Company: _____________________________  Insurance Company: _____________________________
Name: ___________________________  DOB. __/__/____  Name: ___________________________  DOB. __/__/____
S.S.#: ___-___-____  Phone #: (___)_________  S.S.#: ___-___-____  Phone #: (___)_________
Address: _____________________________________  Address: _____________________________________
(Only if Different from patients)  Relationship to patient: _____________________________

Responsible Party Information  **Please fill out section below if patient is under 18 or a Dependant.**
~STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY~

Name: ___________________________  Relationship to Patient: ___________________________
Mother: ___________________________ Phone_________________  Father: ___________________________ Phone_________________
Mailing Address: ___________________________  City: ___________________________  State: ______  Zip: _____________
DOB: __/__/____  S.S.#: ___-___-____  Employer: ___________________________

I authorize the providers in the above named clinic to treat the person whose name appears in the patient information section.

*Patient Signature/Guardian Party’s Signature  Date

I hereby authorize the above named clinic to furnish the insured’s insurance company all information it may request concerning my medical care. I hereby assign to the provider(s) all money to which I am entitled for expense(s) relative to the services performed from time to time, but not to exceed my indebtedness to said provider(s). I understand I am financially responsible to said provider(s) for charges not covered by this agreement.

*Patient Signature/Guardian Party’s Signature  Date

I have been offered South Hilyard Clinic’s privacy policy statement?  Received  Declined

*Patient Signature/Guardian Party’s Signature  Date

Please see reverse side ➔
NEW PATIENT HISTORY FORM

Name: ____________________________ Birthdate: ________________ Date: __________________

SOCIAL HISTORY

Single ______ Married ______ Separated ______ Divorced ______ Widowed ______ Domestic Partnered ______
Who lives in your household? __________________________________________________________
Where do you work? _________________________________________________________________
How much caffeine do you consume per day? ______ How much water? ______ How much alcohol? ______
Do you smoke cigarettes? ______ Number of Packs per day? ______ Other tobacco use? ______ Marijuana? ______
What do you do for exercise (what/how often)? __________________________________________

Please list all medications: (prescribed, Over the counter, and Vitamins)
________________________________________________________________________

FAMILY HISTORY

(PLEASE GIVE APPROX. AGE WHEN PERSON HAD THE ILLNESS)

<table>
<thead>
<tr>
<th>Heart Attack</th>
<th>Stroke</th>
<th>Diabetes</th>
<th>Kidney Disorder</th>
<th>High Blood Pressure</th>
<th>Cancer</th>
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List any other diseases in the family: ________________________________________________

YOUR MEDICAL HISTORY

What serious illnesses did you have as a child? _________________________________________

What illnesses or problems have you had as an adult? _________________________________

Hospitalization: List every time you have been hospitalized overnight

Date: ____________ What was wrong? ____________ What happened? ____________ Any ongoing problems? ____________

Date: ____________ What was wrong? ____________ What happened? ____________ Any ongoing problems? ____________

Date: ____________ What was wrong? ____________ What happened? ____________ Any ongoing problems? ____________

Date: ____________ What was wrong? ____________ What happened? ____________ Any ongoing problems? ____________

Surgeries: ________________________________________________________________

VACCINATION HISTORY: (GIVE APPROXIMATE DATES OF IMMUNIZATIONS)

MMR ______ DT (Tetanus) ______ Pneumonia ______ TB Skin Test ______
Hepatitis A ______ Hepatitis B ______ Flu ______

ALLERGIES

Drug: ____________________________ Food: ____________________________

Any other allergies: _________________________________________________________

Do you have an Advanced Directive? __________________________________________
**Name:**

**Date of Birth:**

### Review of Systems: Please mark an x if you have experienced in the last month.

#### General:
- Unusual fatigue? 
- Chills or fever? 
- Weight loss or gain? 
- Change in heat or cold tolerance? 

#### Skin:
- Acne? 
- Rash or hives? 
- Possible cancer spots? 

#### Eyes, Ears, Nose, Throat:
- Eye pain? 
- Double vision? 
- Blind spells? 
- Change in vision? 
- Earaches? 
- Hearing Loss? 
- Ringing in ears? 
- Sinus pain? 
- Nose bleeds? 
- Difficulty swallowing? 
- Sore throat? 
- Change in vision? 

#### Breasts:
- Lumps? 
- Breast pain? 
- Nipple discharge? 
- Nursing? 

#### Heart and lungs:
- Chest pain? 
- Irregular heart beat? 
- High Blood pressure? 
- Swollen feet or ankles? 
- Shortness of breath? 
- Wheezing? 
- Discolored hands or feet? 

#### Gastrointestinal:
- Heartburn? 
- Bloody or black stools? 
- Change in stools? 
- Constipation? 
- Diarrhea? 
- Hemorrhoids? 
- Nausea/Vomiting? 
- Stomach pain/Cramps? 

#### Genital/Urinary:
- Blood in urine? 
- Leaking Urine? 
- Painful urination? 
- Up at night more than x2 to urinate? 
- Sexual concerns? 
- Sexually transmitted infections? 
- Discharge from penis or vagina? 
- Lumps or pain in testicles? 

#### Neurologic:
- Tremor? 
- Coordination problems? 
- Frequent headaches? 
- Memory problems? 
- Dizziness? 
- Fainting Spells? 
- Persistent numbness? 
- Localized weakness? 

#### Mood/Mental Health:
- Fatigue? 
- Sleep Problems? 
- Change in appetite? 
- Depressed or Sad? 
- Suicidal thoughts? 
- Concentration problems? 
- Anxious, or worried? 
- Marital, family, or work problems? 

#### Bones/Joints:
- Back strain? 
- Painful or Stiff joints? 
- Redness of Joints? 
- Neck pain? 

PLEASE LIST ANY OTHER CONCERNS REGARDING YOUR HEALTH:
We may use or disclose health information about you for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

- **For payment.** We may use and disclose health information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party.

- **For Health Care Operations.** We may use and disclose health information about you in order to run our office and make sure that you and our other patients receive quality care.

- **For Research.** We may use and disclose health information about you for research projects that are subject to special approval processes. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- **For Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **Workers' Compensation.** We may use health information to settle claims filed under workers’ compensation laws.

- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, you may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.
in situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person’s involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Officer in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our Privacy Officer.

  You have the right to request a copy of your health information, in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by our office.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our Privacy Officer.

  We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be (number) of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

  To obtain this list, you must submit your request in writing to our Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions “out of pocket” and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to our Privacy Officer.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice anytime. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy on our website.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

We will inform you of any significant changes to this Notice. This may be through a newsletter, a sign prominently posted at our office, a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer listed on the first page. You will not be penalized for filing a complaint.
**SOUTH HILYARD CLINIC**

**AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
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<tbody>
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</tr>
</tbody>
</table>

Address:

Please **RELEASE** information FROM:

Physician or Clinic Name

Street Address

City/State/Zip

Phone Number

Fax Number

Please **RELEASE** information TO:

South Hilyard Clinic

3525 Hilyard St. Eugene, OR 97405

Phone: 541-687-8581

Fax: 541-343-1411

Unless otherwise indicated this release is for the purpose of: ___ Consent to communicate only, (Medical records not needed.), ___ Transfer of care, ___ Consult, ___ Other

Please send the past 2 years of clinical notes and lab reports, the past 5 years of imaging, diagnostic tests and operative reports, and all immunization records. Additionally, I especially request records regarding:

---

*I have reviewed and understand this authorization.*

<table>
<thead>
<tr>
<th>Signature of patient or legally responsible person*</th>
<th>Relationship to patient</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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*In the event this Authorization is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached (i.e. Health Care Power of Attorney, or Court appointed Health Care Representative.)*

Unless otherwise revoked, this authorization will expire on the following date:

Effective Date: ____________________  Expiration Date: ____________________

If I fail to specify an expiration date, this authorization will expire 1 year from the date signed.

---

The following must be INITIALED by the requestor to be included in the use and/or disclosure:

- ___ *HIV/AIDS related information and/or records*  ___ Mental Health Information
- ___ Genetic Testing information  ___ **Drug/alcohol treatment**

*This information may not be re-disclosed without the specific written authorization of the individual, except where authorized by law.

**Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.*

In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the purpose of release for HIV/HTLV test results/records: ___ At my request, ___ Other ____________________

These results may be released from this date ____________________ until ____________________ (please enter expiration date).

---

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

1) Creating health information about you to be disclosed to a third party; or
2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Privacy officer at 3525 Hilyard St. Eugene OR 97405 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer can be protected by federal law.

Please allow 30 days for requested information to be transferred.