ONE LOVE *Agency*

**Authorization for Release / Exchange   
Of Medical Information**

Participant: DOB:

I authorize One Love Agency to exchange and/or release my protected health Information (PHI) with the agency or person listed below:

Name:

Address:

Phone: Fax:

Type of PHI to be disclosed to or by One Love Agency:

I am aware that this authorization is Voluntary and if the person or entity authorized by this document to receive my PHI is not a health plan or health-care provider, then the disclosed PHI information may no longer be protected from further disclosure by state and federal law.

This authorization will expire on

I understand that signing this form will not affect my healthcare and I may revoke this authorization at any time by notifying One Love Agency. Furthermore, I understand that my revocation of this form will not affect any actions taken by One Love Agency prior to the time it received my revocation. Also, I may see a copy of the information described on this form if I request it and may get a copy of this form after signing it.

Signature Date

If not signed by patient indicate relationship:

3649 N. Lakeharbor Ln. Phone: 208-991-4296 Fax: 208-853-5377

Boise, ID 83703 www.oneloveagency.org