Patient Name (PLEASE PRINT) | Patient DOB

I hereby acknowledge that I have received or declined a copy of Rogue Valley Physicians, P.C.'s (RVP) **Notice of Privacy Practices (revised date 6/1/2016),** which includes information relating to our participation with Jefferson Health Information Exchange (JHIE)**.**

Initials

☐ **I AGREE** to have RVP release my records to JHIE

☐ **I DECLINE** to have RVP release my records to JHIE

Signature | Date

Signer's Name (if different than Patient)