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's) **Notice of Privacy Practices (revised date 2/27/18),** which includes information relating to our participation with Reliance (formerly Jefferson Health Information Exchange).

Initials

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

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

Signature

Date

Signer's Name (if different than Patient)