Oregon Medical Group

Alternate Contact Information & Family/Friends Release of Information Authorization Form

Patient Label

Patient Name: _____

Patient Date of Birth: _____

Phone Number (Home/Cell):_____

Part I Alternate Contact Information Authorization

Oregon Medical Group has my authorization to:

Y **N** Leave medical information on my home/cell answering machine.

Y **N** Contact me at my place of employment.

Y **N** Leave medical information on voice mail at my place of employment.

Y **N** Fax immunization records to schools and employers upon my verbal authorization.

Part II Family/Friends Release of Information Authorization

I authorize Oregon Medical Group to discuss **any** information regarding my care with below-mentioned persons:
(Only list names of persons you are authorizing to discuss **any** information with.)

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Additional space is available on the back of form if needed to include more family/friends.

Part III Emergency Contacts Only

I authorize Oregon Medical Group to contact the below mentioned person only in the case of an emergency. Below mentioned person (unless listed in Part II) may not receive any additional information regarding my care:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

This form is valid until revoked in writing by the patient.

_____ _____

Signature of Patient or Legal Representative* Date

_____

Print Patient Name /Relationship to Patient

You have the right to revoke this Authorization at any time, provided that 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. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Your health care and payment for health care cannot be conditioned upon receipt of this signed Authorization.

*In the event this Authorization is signed by a legal representative other than the 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.)