Place Patient Label Here

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

Patient Name:_____ **Phone Number:**_____**(Home/Cell)**

Patient Date of Birth: _____ **Phone Number:** _____**(Other)**

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.

(Messages will not be left on answering machines or voice mail if the recorded greeting does not include confirmation of your name or phone number.)

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 us to discuss **ANY** information with.)

Name: _____Relationship: _____

Phone number:_____

Name: _____Relationship: _____

Phone number:_____

Additional space is available on back of form if needed to include more Family/Friends

This Family/Friends Release of Information Authorization (Part II) is valid until _____.
Date or Event (Legal Proceeding)

If no date or event is listed, this authorization will expire one year from the date it was signed.

This authorization may be revoked by the patient in writing at any time.

_____ _____
Patient or Legal Representative Signature* **Date**

_____
Print 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 that health care cannot be conditioned upon receipt of this signed Authorization.

*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.)