ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
Rogue River, Oregon 97537
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CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO FRIENDS OR FAMILY MEMBERS

Patient Name_____ Date of Birth_____

CONSENT

I request Rogue River Family Practice Clinic to release protected healthcare information to:

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

This request and authorization applies to: (please check below)

☐ All healthcare information (Medical and Billing)

☐ Healthcare information relating to the following treatment, condition or dates:

_____

_____

☐ Other_____

I understand that this designation applies only to Rogue River Family Practice Clinic.

Patient Signature_____ Date Signed_____

REVOCATION/TERMINATION

I request to revoke/terminate the designation made above.

Patient Signature_____ Date Signed_____