REQUEST FOR SPECIFIED METHOD OF COMMUNICATION AND RELEASE OF INFORMATION AGREEMENT

INDIVIDUAL TO COMPLETE THE FOLLOWING INFORMATION (please print):

Name (last, first, middle): ____

Address: ____

Telephone No.: ______________________ Date of Birth: ____________________

REQUEST:

I request that communications containing my health information from The Oregon Clinic (TOC) be communicated to me in the following manner:

☐ At the telephone number listed above.

☐ OK to leave me a detailed message

☐ DO NOT leave me a detailed message

☐ At a telephone number other than the telephone number listed above.

Preferred telephone number: ______________________

☐ OK to leave me a detailed message

☐ DO NOT leave me a detailed message

☐ At a mailing address other than the address listed above. Preferred mailing address is:

____

☐ Via MyChart or patient portal

☐ Other. Please specify: ____

If the specified method of communication is accepted, this method of communication will expire after one year from the date of signing or shall remain in effect for the period stated here (alternate date):

____

Date: ______________________

Signature of Patient/Legal Representative of Patient: ______________________

Print Name of Legal Representative: ______________________

RELEASE OF INFORMATION AGREEMENT:

Please enter contact information for your **approved family/caregivers** who are involved in your care or payment related to your health care.

Name	Phone Number	Relationship
1.		
2.		
3.		

I understand that TOC may disclose to the persons I named above my protected health information that is directly relevant to that person's involvement with my health care or payment related to my health care.

I understand that the individuals I named above will **not** be given any information about the following (if applicable), **unless I sign a separate authorization for the release of information**:

- HIV/AIDS
- genetic testing information
- mental health information, and
- drug/alcohol diagnosis, treatment, or referral information.

This release expires one year from signing, unless revoked or otherwise specified below (alternate date): ____

Date: ______________________________

Signature of Patient/Legal Representative of Patient: ___________________________________

Print Name of Legal Representative: ____