

Place Patient Sticker Here

PATIENT INFORMATION

Name (last, first, middle): _____

Telephone No.: _____

Date of Birth: _____

COMMUNICATION 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 above. Preferred telephone no.: _____
 - OK to leave me a detailed message
 - DO NOT leave me a detailed message
- Preferred mailing address: _____
- Via MyChart or patient portal
- Other. Please specify: _____

If accepted, this method of communication expires 2 years from signing, unless an alternate date is specified: _____

RELEASE OF INFORMATION AGREEMENT

Please enter contact information for approved family/caregivers 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 named above my protected health information directly relevant to that person's involvement with my health care or payment related to my health care.

The individuals named above will NOT receive information about the following unless I sign a separate authorization:

- HIV/AIDS • Genetic testing information • Mental health information
- Drug/alcohol diagnosis, treatment, or referral

This release expires 2 years from signing, unless revoked or otherwise specified below (alternate date): _____

Date

Signature of Patient / Legal Representative

Print Name of Legal Representative (if applicable)