HOLY FAMILY CATHOLIC CLINIC

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

21810 Willamette Drive, #200
West Linn, OR 97068

1829 NW Kings Boulevard
Corvallis, OR 97330

Patient Name: _____ Date of Birth: _____

Types of Information to be Released:

□ Billing & Payment Information ONLY

□ ALL Medical Information *Including, but not limited to: Billing/Insurance/Payment, Mental Health, Drug/Alcohol, HIV/AIDS*

I give permission to Holy Family Catholic Clinic, P.S. to verbally discuss information about me with the following friend or family member(s):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: (_____) _____ Phone: (_____) _____

This authorization shall remain in effect until: _____ (specify date or event)

□ NO EXPIRATION DATE

If you wish to DECLINE Release of Information, HFCC will not be authorized to speak to anyone on your behalf.

□ DECLINE Release of Information

I understand that this authorization may be revoked at any time in writing to the address above. No revocation will be retroactive to pertain to information already released.
I understand that my establishing or receiving medical care is NOT contingent upon signing this form. I understand the release of this information is intended to assist the physicians at Holy Family Catholic Clinic, P.S. (HFCC) to care for the patient indicated above. I understand that the information disclosed may be subject to re-disclosure. The undersigned hereby releases HFCC from any liability which may arise from the release and/or examination of the information indicated above. I have read this authorization, and I understand it.

_____ _____

*Signature of Patient or Legal Representative** *Date*

**If legal representative, please sign & attach copies of supporting legal documentation*