White Bird Medical Clinic
1400 Mill St.
Eugene, OR. 97401
P) 541-484-4800
F) 541-344-8351

Date: _____

Authorization for Release of Information to Family and/or Friends:

Name of Patient: _____ **Date of Birth:** _____

White Bird Medical Clinic is authorized to release health information pertaining to the above named patient to the entities below.

1.) Name/ Relationship: _____ DOB: _____

2.) Name/ Relationship: _____ DOB: _____

3.) Name/ Relationship: _____ DOB: _____

4.) Name/ Relationship: _____ DOB: _____

Description of Information to be released:

_____Financial Information

_____Results for, tests and/or x-rays

_____ Billing Information

_____Medical information as follows: _____

_____Other information as described: _____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Any information received by this office for our own use will continue to be protected by the Federal and State Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Signature of Patient/Personal Representative Expiration date (1 year if not specified)

_____

Description of Personal Representative's Authority (attach necessary documentation)