THE OREGON CLINIC

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 number: _____

Medical Record No.: _____ Date of Birth: _____

REQUEST:

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

☐ At a telephone number other than my home number. Preferred phone number: _____.

☐ OK to leave me a detailed message

☐ DO NOT leave me a detailed message

☐ At a mailing address other than my home mailing address. 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 365 days from the date of signing or shall remain in effect for the period stated here (alternate date): _____

I understand that this request is only for an alternative manner or method of receiving communications from the service area/specialty clinic specified above. I also understand that this request does not include other service areas/specialty clinics within The Oregon Clinic.

Date: _____

Signature of the Patient/Legal Representative of Patient: _____

Print Name of Legal Representative: _____

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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
- reproductive health (OB/Gyn)
- 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 the Patient/Legal Representative of Patient: _____

Print Name of Legal Representative: _____