OREGON UROLOGY INSTITUTE

2400 Hartman Lane • Springfield, OR 97477
Phone: 541-334-3350 • Fax: 541-746-4569

Release of Information

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Release to Email:	Can we release information to your email address on file?	□ Y □ N
Release to Home Phone:	Do you want us to leave medical information on your home phone number and voicemail?	□ Y □ N
Release to Cell Phone:	Do you want us to leave medical information on your cell phone number and voicemail?	□ Y □ N
Release of Information Confirmation:	Is there someone we have permission to contact or share medical information with on your behalf? This allows Oregon Urology Institute PC, and Oregon SurgiCenter, PC to discuss ANY and ALL information regarding my care with below-named individuals. (Only list names of persons you are authorizing to discuss ANY and ALL information with.)	□ Y □ N
Release of Information:	You give permission to the doctor and staff to release information to:	_____
First Individual's Phone Number:	Enter the phone number of the first individual to whom the doctor and staff have permission to release information:	_____
Relationship to First Individual:	Spouse/Partner, Child, Parent Family Member, Friend, Other/Not Listed	
Release of Information-Additional Individuals:	Are there any other individuals who you give permission to the doctor and staff to release information to?	□ Y □ N
Release of Information-Second Individual:	You give permission to the doctor and staff to release information to:	_____
Second Individual's Phone Number:	Enter the phone number of the first individual to whom the doctor and staff have permission to release information:	_____
Relationship to Second Individual:	Spouse/Partner, Child, Parent Family Member, Friend, Other/Not Listed	
Release of Information-Third Individual:	Are there any other individuals who you give permission to the doctor and staff to release information to?	□ Y □ N
Release of Information-Third Individual:	You give permission to the doctor and staff to release information to:	_____
Third Individual's Phone Number:	Enter the phone number of the first individual to whom the doctor and staff have permission to release information:	_____
Relationship to Third Individual:	Spouse/Partner, Child, Parent Family Member, Friend, Other/Not Listed	

_____

Patient Signature: Date: