Oregon Specialty Group

Authorization for Release of Information

Patient's name: _____ Date of Birth: _____

Preferred Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Alternate Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Please select one of the following:

☐ **YES**, you may leave a detailed voicemail message regarding my care when calling the phone number(s) listed above (appointment/scheduling reminders, lab and imaging results, basic information).

☐ **NO**, you may NOT leave a detailed voicemail message regarding my care when calling the phone number(s) listed above.

The individuals (not physicians) listed below are involved in my care. I give my consent and/or authorization for them to discuss my medical condition, confirm appointment times, request records, pick up prescriptions, update my address and phone number, and/or discuss financial information, unless otherwise specified, with the following practices of Oregon Specialty Group (please select):

☐ **Oregon Oncology Specialists** ☐ **Oregon Rheumatology Specialists**

☐ **Oregon Specialty Infusion** ☐ **Oregon Infectious Disease Specialists**

	First & Last Name:	Relationship to Patient:	
1.	_____	_____	☐ **All** information ☐ Other: _____
2.	_____	_____	☐ **All** information ☐ Other: _____
3.	_____	_____	☐ **All** information ☐ Other: _____
4.	_____	_____	☐ **All** information ☐ Other: _____

This authorization for release of information will remain in effect unless I revoke it.

_____ _____

Signature Date