Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

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Tigard, OR 97223

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Release of Information

Instructions: Fill in the name of any person(s) to allow Southwest Family Physicians to discuss your medical information with them.

I, _____, with date of birth, _____, give the providers and office staff of Southwest Family Physicians permission to discuss my medical condition with the listed person(s) below. Southwest Family Physicians may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

Please **initial** the information you want disclosed:

_____ Information relating to my medical treatment

_____ Psychiatric disorders/Mental health

_____ Alcohol/Substance abuse

_____ Sexually Transmitted Diseases/HIV

_____ All other health information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Note: This authorization does NOT allow for the sharing of copies from the patient's health record. If there is an anticipated need for copies of the patient's health record, our standard form must be completed and submitted to the medical records department.

The consent will be considered valid for 2 years or until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Patient name: _____ Date of birth: _____

Signature: _____ Today's date: _____