BENSON HEALTH CLINIC
*66 Club Rd. Suite # 160 Eugene, OR 97401*
*PO BOX 70779*
*Springfield, OR 97475*
Ph: 541-345-1722 Fax: 541-485-7049

# Family/Friend Release of Information

I ____________________________________ ___________________________
(Print patient full name) (date of BIRTH)

Hereby authorize the providers and staff of Benson Health Clinic to inform and/or involve the following family members or friends of my care, treatment plan, appointments, or account status. I understand that this release will also allow the person(s) I have listed below to share information with the providers or staff regarding my condition.

__________________________________________ __________________________
Name Relationship Phone number

_________________________________________ __________________________
Name Relationship Phone Number

_________________________________________ __________________________
Name Relationship Phone Number

_________________________________________ __________________________
Name Relationship Phone Number

This authorization will remain in effect for the duration of my treatment or until revoked in writing by the patient.

By signing below I understand that the information specific to Drug and alcohol treatment, psychiatric treatment, AIDS/HIV, and genetic test information can be released with this consent.

I understand information discussed may be re-disclosed by the receiving person and may no longer be covered under federal privacy laws.

______________________________________________________________________
Patient Signature Date

______________________________________________________________________
Authorized Representative Signature Date