BENSON HEALTH CLINIC
66 Club Rd. Suite # 140 Eugene, OR 97401
PO BOX 70779 Springfield, OR 97475
Ph: 541-345-1722 Fax: 541-485-7049

Shared/Release of Information

I ________________________________ ________________________
(Print patient full name) (Date of BIRTH)

Hereby authorize the following to make/cancel appointments, discuss account balances, pick up items left for me from my provider (i.e. letters, sample medication, prescriptions, etc.) only.

______________________________________ ________________________
Name Relationship Phone number

______________________________________ ________________________
Name Relationship Phone Number

The following I hereby authorize the providers and staff of Benson Health Clinic to inform and/or involve the following friends or family members 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

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

Initial below if you consent to having specific Drug and alcohol treatment, psychiatric treatment (i.e. diagnoses, symptoms, medications), AIDS/HIV, and genetic testing information released to the following people listed above.

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Initials

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

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Authorized Representative Signature Date