SPORTS MEDICINE
OREGON

Release of Information Authorization Form

Patient Name: _____ Date of Birth: _____

Without your prior approval, Sports Medicine Oregon Staff cannot discuss any medical information with family or friends. Please list the names of people you would like listed to be involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for the information regarding my current health status be discussed with:

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand this might include information regarding my diagnosis, prognosis, treatment plan, medications, discharge instructions, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

Signature: _____ Date: _____

☐ I decline to have my medical information discussed with family or friends