BACK  to Health Clinic

PERMISSION TO RELEASE CONFIDENTIAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE.

IMPORTANT NOTICE: The law prohibits the release of confidential medical information to an entity without the written voluntary consent of the undersigned patient.

Name of Patient: _____ Date of Birth: _____

- ❖ BACK to Health Clinic may leave messages on my phone YES NO
- ❖ I authorize BACK to Health Clinic to confirm appointments and/or discuss information regarding my medical condition with: (spouse, relatives, friends)

_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

If you do not want any information given to anyone other than yourself please initial here_____

I understand this Authorization. I also understand that the information used or disclosed may be subject to re-disclosure by the recipient and no longer protected under federal law. I understand this document is not a release of medical *records*.

_____	_____
Signature of Patient	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Printed Name of Legal Representative	Date

BACK to Health Clinic
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Keizer, OR 97303