Reese Family Practice

HEALTH INFORMATION RELEASE FORM

1755 Coburg Rd. Suite 602 ● Eugene, OR 97401 ● Office 541-255-3905 ● Fax 541-636-4339

I, _______________________________hereby authorize the following person(s):

_________________________**Phone Number:**________________________ **Relation:**__________

☐ By checking this box the above person will also be used as an emergency contact.

_________________________**Phone Number:**________________________ **Relation:**__________

☐ By checking this box the above person will also be used as an emergency contact.

To be provided with all information regarding my health care including, but not limited to any medical visits, lab results, test results, medications, doctors' orders, diagnosis, treatment plans, and other such information necessary for my care and treatment.

By signing this form I agree with the above listed people being provided this information.

________________________________ __________

Patient Date

________________________________ __________

Witness Date