Clinic Family and Friends Authorization Form

Patient Name:_____ **Date of Birth:** _____

As a patient of Portland Surgeons, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my current health status to be discussed with:

Name	**Relationship**	**Telephone**
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Name	**Relationship**	**Telephone**

_____ **Not applicable - No pertinent family**

_____ **Do not share my medical information with any family or friends.**

_____ **Do NOT share with**

Name	**Relationship**

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

Signature: _____ _____

Patient or Personal Representative **Today's Date**