

WEST LINN FAMILY HEALTH CENTER, P.C.

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PHONE 503•635•8384 FAX 503•636•6475
www.WestLinnFamilyHealthCenter.com

INFORMATION RELEASE

VOICEMAIL RELEASE

I authorize West Linn Family Health Center employees to leave test results in the voice mail boxes at the following phone numbers:

Phone: _____ home cell work
Phone: _____ home cell work
Phone: _____ home cell work

This authorization will remain in effect while I am under the care of West Linn Family Health Center. I understand that I can revoke this authorization at any time in writing.

Print Patient Name _____ Date of Birth _____

Signature: _____ Today's Date _____

COMMUNICATION RELEASE

I authorize West Linn Family Health Center to share my medical records and information with the person(s) named below:

Name: _____ relation: _____

Name: _____ relation: _____

Name: _____ relation: _____

This authorization will remain in effect while I am under the care of West Linn Family Health Center. I understand that I can revoke this authorization at any time in writing.

Print Patient Name _____ Date of Birth _____

Signature: _____ Today's Date _____