FAMILY INFORMATION EXCHANGE/RELEASE OF INFORMATION, VERBAL OR WRITTEN

(To be signed by patient, parent, guardian, or Power of Attorney)

I,_____, hereby authorize Oregon Ear, Nose and Throat, P.C. to inform and/or
Patient Name-please print
involve the following family members and friends in my care planning. I understand that their participation will include giving information to the staff of Oregon Ear, Nose and Throat, P.C. regarding my condition. I also understand that the staff of Oregon Ear, Nose and Throat, P.C. may share information with the family and/or friends listed below about my care planning.

Spouse or primary significant other:

Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work

Other family and friends:

Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work
Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work
Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work

I understand that information specific to drug and alcohol treatment, psychiatric treatment, and AIDS/HIV testing may be released with this consent. I can cancel this at any time, but I understand that the cancellation will not affect any information that was released prior to the cancellation. I understand what this agreement means and I am satisfied with any explanations I may have requested and received.

Patient Signature		Date
Authorized Signature	Relationship	Date