

LA PINE COMMUNITY HEALTH CENTER

51600 Huntington Road-PO BOX 3300-La Pine, Oregon 97739
541-536-3435 and 541-536-8047 (fax)

Special Information Permission Request

A. Phone Messages Regarding Appointment Information:

I give my permission for La Pine Community Health Center to leave messages regarding appointments on my voicemail at home or my cell phone.

I **DO NOT** give my permission for La Pine Community Health Center to leave messages regarding appointments on my voicemail at home or my cell phone.

Patient's Signature: _____ Date: _____

B. Messages Regarding Treatments, Billing, and/or Appointment Status:

I give my permission to have **messages** regarding my healthcare treatment plan, billing and/or appointment status with my spouse/partner/caregiver:

Name of Spouse/partner/caregiver (PLEASE PRINT)

I **DO NOT** give my permission to have **messages** regarding my healthcare treatment plan, billing and/or appointment status with my spouse/partner/caregiver.

Patient's Signature: _____ Date: _____

C. Medical Information Discussions:

I give my permission to discuss my medical records/care/treatment plans/management with:

Name of Spouse/partner/caregiver (PLEASE PRINT)

I **DO NOT** give my permission to **discuss any** of my medical records/care/treatment plans/management with anyone other than myself.

Patient's Signature: _____ Date: _____

D. Cancellation of Personal Health Information Release:

This release will be revoked by written permission only. I understand that I must send a written request to La Pine Community Health Center in order to revoke this release of my personal health information.

Patient's Signature: _____ Date: _____