



# ASHLAND FAMILY PRACTICE

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*Cynthia Parks-Landis, F.N.P. Jennifer Moss, F.N.P.  
Rebecca Bolling, F.N.P.*

## Release of Information

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Do you have a Power of Attorney?  Yes  No

If yes, please provide us with the following information and all related forms:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health operations.)**

Name	Phone #	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:**

Name	Phone #	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?**

Home  Cell  Work  No Messages

Patient Signature: \_\_\_\_\_ (Guardian if under 18 years)

Date: \_\_\_\_\_