Oregon Psychiatric Partners, L.L.P.
&
Franc Strgar, MD, P.C.
3203 Willamette Street ~ Eugene, OR 97405
Phone 541-726-9912 ~ Fax 541-744-4443

FAMILY/FRIEND RELEASE OF INFORMATION FORM

I, ______________________________________ ____________________
(print patient name) (patient date of birth)

hereby authorize the providers and staff of Oregon Psychiatric Partners LLP and Franc Strgar MD PC to inform and/or involve the following family members and friends in my care and treatment planning. I understand that the providers and staff may verbally share information with the family and/or friend(s) listed below about my care plan, appointments, or account status. I understand that this release will also allow persons I have listed below to share information with the providers and staff regarding my condition.

Family and friends:

1. ______________________ __________ Relation ______________ Address/Street Phone/Home
______________ City/State/Zip Phone/Work

2. ______________________ __________ Relation ______________ Address/Street Phone/Home
______________ City/State/Zip Phone/Work

3. ______________________ __________ Relation ______________ Address/Street Phone/Home
______________ City/State/Zip Phone/Work

4. ______________________ __________ Relation ______________ Address/Street Phone/Home
______________ City/State/Zip Phone/Work

This authorization will remain in effect for the duration of my treatment or until cancelled in writing by the patient.

I understand I can cancel this release at any time, but the cancellation will not affect any information that was already released before the cancellation.

By signing below I understand that information specific to drug and alcohol treatment, psychiatric treatment, AIDS/HIV, and genetic test information can be released with this consent.

I understand information discussed may be re-disclosed by the receiving person and may no longer be covered under federal privacy laws.

I understand what this agreement means and I am satisfied with any explanations I may have requested and received.

______________________________________ ______________
Patient Signature Date

______________________________________ ______________
Person authorized to sign Relationship Date