Youth & Family Services
P.O. Box 20400 - Keizer, OR 97307
2933 Center Street NE - Salem, OR 97301
503-362-2225

Rainbow Family Services
800 Second Street NE
McMinnville, OR 97128
503-472-2240

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, authorize _____
(patient – TFP applicant) ***(name of physician)***

to release medical information to Youth & Family Services or Rainbow Family Services.

This release is effective beginning and ending on the following dates:

_____, to _____.
(current date to one year from current date)

The purpose of releasing this information is to assure I have no medical condition, which prohibits me from performing my duties as a treatment foster parent (TFP).

_____ _____
Patient/TFP Signature *Date*

CERTIFICATE OF HEALTH STATUS

_____ has no medical condition that would prohibit the
(patient – TFP applicant)

competent performance of the treatment foster parent duties as outlined by Youth & Family Services or Rainbow Family Services policies and procedures. Neither is there any condition that would jeopardize the health of any youth placed in this TFP's care.

_____ _____
Physician's Signature *Date*