CATHOLIC COMMUNITY SERVICES

YOUTH & FAMILY SERVICES
2933 Center Street NE
Salem, OR 97301
503-362-2225

RAINBOW FAMILY SERVICES
800 Second Street
McMinnville, OR 97128
503-472-2240

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, **(name of TFP)**

authorize _____ **(name of physician)** to release medical information to Catholic Community Services.

This release is effective beginning and ending on the following dates: _____, to _____.

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

_____ **(name of Treatment Foster Parent - TFP)**

has no medical condition that would prohibit the competent performance of the treatment foster parent duties as outlined by Catholic Community 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