Authorization to Disclose Protected Health Information

NEIGHBORHOOD HEALTH CENTER

10330 SE 32nd Ave, Ste 325 Milwaukie, Or 97222 • Phone: 503-416-1960 • Fax: 503-416-1959

Section 1

Patient Name: _____ Date of Birth: __/__/__

Previous Name: _____ Social Security #: _____

Section 2

Purpose of this disclosure (check all that apply):

□ Transfer of Patient Care □ Coordination of Care □ At Request of the Patient

□ Legal □ Prenatal Care □ Eligibility Determination

Section 3

I request and authorize the individual/Clinic/Provider listed below to release/receive a copy of my medical record:

□ I want to send my records **from NHC to**: □ I want to send my records **to NHC from**:

Section 4

_____ _____

Name of Individual/Clinic/Provider Phone

_____ _____

Address Fax

_____ _____ _____

City State Zip Code

Section 5

This authorization gives permission to release the following records:

□ **Entire Medical Record** □ Immunization/Lab Results (describe): _____

□ X-Ray Films (describe): _____

□ Other (describe): _____

Section 6 (optional)

I understand that certain information cannot be released without specific permission as required by State/Federal law. By <u>INITIALING</u>, I authorize the release of the following protected or sensitive information.

Please Initial		Please Initial	
_____	Drug/Alcohol Diagnosis/Treatment/Referral Information	_____	STD/AIDS/HIV Testing
_____	Mental Health Diagnosis/Treatment	_____	Genetic Testing

_____ _____ _____

Signature (Patient, Guardian, or Authorized Person) **Relationship to Patient** **Date**

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to Neighborhood Health Center and state that you are revoking this authorization. Unless revoked earlier, this consent will expire upon the event or date indicated: _____or after one year from the date signed if left blank.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.516) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

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Patient must complete this section. If not complete, it may be sent back to you.

Section 1: Complete each box as indicated with the following information:

- Patients Name (Print Clearly)
- Other names patient has used. If none, leave blank
- Date of Birth
- Social Security Number

Section 2: Check the purpose for disclosure or need for the exchange and disclosure of this information

Section 3: Check whether you are requesting records to be sent **from** Neighborhood Health Center or if you are requesting records **to** be sent to Neighborhood Health Center

Section 4: Write the name or company that is to receive/release the information.
Include as much as information as you can:

- Name or Company
- Address (including city, state and zip code)
- Phone number
- Fax number

Section 5: Check the box that applies to your request:

- Checking ENTIRE MEDICAL RECORD will allow the release of your whole records except for the sensitive information unless otherwise specified (see section 6)
- Please be specific and describe what x-ray, laboratory results, immunizations or other information being requested.

Section 6: INITIAL for any sensitive information protected by law you want to be released.

Please sign your name, authorizing the information on the release is correct and approved by you. If you are not the patient, describe your relationship and legal authority to sign. You will be required to provide the legal paperwork.

Date the Authorization