Authorization to Release Healthcare Information

Please select dental clinic location:

❑ Milwaukie - 3300 SE Dwyer Drive #302, Milwaukie OR 97222 Phone: 503-850-4479 Fax: 503-850-4481

❑ Tanasbourne - 18650 NW Cornell Road #220, Hillsboro OR 97124 Phone: 503-848-5861 Fax: 503-848-5863

❑ Oregon City - 19029 S Beavercreek Road, Oregon City OR 97045 Phone: 503-941-3064 Fax: 503-941-3075

Email: dentalinfo@nhcoregon.org

Patient's Name: ____ **Date of Birth**: ___________________

I request and authorize the providers/individuals listed below to release and/or receive a copy of my record (please circle):

- To send records **FROM** NHC to: ____
  Clinic/Provider Name
- To give records **TO** NHC from: ____
  Address
- To **VERBALLY** exchange with: ____
  Phone Fax

This request and authorization applies to:

___ All healthcare/dental information (including radiographs)

___ Healthcare/dental information relating only to the following treatment, condition, or dates:

____

Purpose for this disclosure (check all that apply):

❑ Dental Care ❑ Legal ❑ Eligibility Determination ❑ At the request of the patient ❑Other (specify): ______________________

X____ ______________________

Signature (patient, guardian, or person authorized to sign for patient) ***Date***

____ ____________________________

Name (please print) ***Relationship to Patient***

I understand that I may revoke this authorization in writing 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.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us your written permission to release your information back to them, then we may not provide you with that health service. 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 @, 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.