



Authorization to Disclose Protected Health Information From NUNM Health Centers

*Patient Name: _____ *Date of Birth: ___/___/___ *Phone: _____

*Address: _____
Mailing address City State Zip

I hereby authorize the NUNM Health Centers to disclose my healthcare information to:

*Name: _____ Phone: _____
Provider / healthcare facility name

Fax: _____

*Address: _____
Mailing address City State Zip

*To disclose my healthcare information from this NUNM Provider _____ at the following location (a list of all of our locations is on the following page):

NUNM Lair Hill Health Center
3025 SW Corbett Ave
Portland, OR 97201
Phone: 503.552.1551
Fax: 503.226.8133

NUNM Community Health Centers
Health Center: _____
Fax: _____
(list of Health Centers fax on back of form)

*By **CHECKING** the spaces below, I authorize release of the following records:

- ___ Lab / Pathology reports – past 6 months
- ___ Lab / Pathology reports – past 1 year
- ___ Imaging reports – past 6 months
- ___ Clinical records from ___/___/___ to ___/___/___
- ___ Imaging reports – past 1 year
- ___ Other – Please be specific _____
- ___ **Clinical Summary – includes Problem & Medication Lists**

- The following items must be **INITIALED** to be included in records to be released:
 - ___ HIV/AIDS related record
 - ___ Drug/Alcohol diagnosis, treatment or referral information
 - ___ Mental Health records
 - ___ Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed). Describe _____

For the specific purpose of: _____

This authorization will expire 180 days from the date of signing. As required by the Privacy Regulations, NUNM Health Centers may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose Protected Patient Health Information.

_____/_____/_____
*Signature of Patient or Patient's Authorized Representative (Relationship) *Date

*Minors- a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

NUNM Health Centers Locations:

BEAVERTON

NUNM Beaverton Health Center
11975 SW 2nd St
Fax: 503.430.7914

SW PORTLAND

Pivot
209 SW 4th Ave.
Fax: 503.226.8133

NW PORTLAND

Rose Haven
627 NW 18th Ave.
Fax: 503.226.8133

NE & N PORTLAND

PCC Workforce
5600 NE 42nd Bldg 2
Fax: 503.226.8133

Mt. Olivet
8725 N. Chautauqua
Fax: 503.226.8133

****If you are requesting records on behalf of one of the following organizations, please contact their facility directly; Pacific Psychology Clinic, Asian Health & Service Center, VOA WRC, VOA MRC, In Act, Beavercreek Clinic***