

**Authorization to Disclose Protected Health Information From The
NUNM HEALTH CENTERS - BEAVERTON**

*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

*Address: _____
Mailing address City State Zip

***To disclose my healthcare information from this NNM Provider _____ at the following location:**

NUNM Health Centers - Beaverton
11975 SW 2nd Street Suite 110
Beaverton, OR 97005
Phone: 503.372.9824
Fax: 503.430.7914

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

___ Lab / Pathology reports – past 6 months ___ Imaging reports – past 1 year
___ Lab / Pathology reports – past 1 year ___ Clinical records from ___/___/___ to ___/___/___
___ Imaging reports – past 6 months ___ 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 ___ Mental Health records
___ Drug/Alcohol diagnosis, treatment or referral information ___ 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

***REQUIRED to process request. Thank you!**