**Authorization to Disclose Protected Health Information To The**

# NUNM Health Centers - Beaverton

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

*Address: _____
*Mailing address* *City* *State* *Zip*

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

***Address: _____**
***Mailing address*** ***City*** ***State*** ***Zip***

***To disclose my healthcare information to this 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
____Lab / Pathology reports – past 1 year
____Imaging reports – past 6 months
____Imaging reports – past 1 year
____Clinical records from ____/____/_____to __/____/_____
____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!***