NUNM Health Centers
3025 SW Corbett Ave
Portland, OR 9720

Patient Authorization for Family/Friend/Other to Receive Health Information

_____ _____
Patient Name Date of Birth

Patient or Legally Authorized Representative to complete the following:

I authorize NUNM Health Centers to discuss/provide the information specified below to the following individual:

Name: _____ _____
PRINT *name of person to receive information* Date of Birth

*Patient or Representative needs to **INITIAL** the desired information to be disclosed:*

- Recent Patient Visit _____
- Care Instructions _____
- Prescription Information _____
- Lab Results _____
- Billing _____

Specify any other restrictions or release of information to the party specified above:

_____

This authorization is valid as of _____ and expires as of _____ (up to one year later).

I acknowledge that I have read and fully understood this consent form. I also understand that I have the right to revoke this authorization at my time by providing written notice to NUNM Health Centers. I understand that my written revocation is not applicable to information already disclosed while the authorization was in effect.

Signed: _____ Date: _____
Patient or Legally Authorized Representative

Witness: _____ Date: _____