



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:

NUNM Health Centers - Medical Records Department
3025 SW Corbett Ave Portland, OR 97201
Phone: 503.552.1551 Fax: 503.226.8133

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

\*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).