AUTHORIZATION TO RELEASE MEDICAL INFORMATION

REASON FOR REQUEST	
☐ Personal	☐ Permanent Transfer to a New Provider
☐ Medical Care	
☐ Benefits	☐ Other: _____

Patient Name			
Birth Date		**Social Security # (Last 4 Digits)**	
Current Address			
Phone Number		**E-mail Address:**	

I AUTHORIZE INFORMATION RELEASE FROM:
Name of Facility/Provider Sending Information
Address of Facility/Provider
City, State, and Zip Code
Note: If addresses are not provided, it may cause a delay in your request.

INFORMATION TO BE RELEASED TO:	
Name of Facility/Provider Receiving Information	
Address of Facility/Provider	
City, State, and Zip Code	
Phone #	*Fax # (REQUIRED)*

TYPE OF INFORMATION TO BE RELEASED *(SELECT ALL THAT APPLY)*

☐ Chart Notes ☐ Medications ☐ Other: _____

☐ Laboratory Results ☐ Immunizations _____

DATES OF SERVICE *(SELECT ONE OF THREE OPTIONS)*

☐ Most Recent Visit ☐ Last 2 years ☐ From (MM/DD/YYYY) To (MM/DD/YYYY)

FORMAT OF RECORDS TO BE SENT *(SELECT ONE)*

☐ DVD
☐ Paper
☐ Patient Portal
☐ Thumb Drive

☐ Other: _____
_____

METHOD OF DELIVERY *(SELECT ONE)*

☐ Mail
☐ MyChart
☐ Fax*
☐ Other: _____
_____

**If page count is high, the document(s) will be mailed.*

PROTECTED OR SENSITIVE INFORMATION

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to use and disclosure of the information may apply. By initialing beside each, I understand and agree that this information will be disclosed.

_____ HIV / AIDS Information
Initials

_____ Mental health information
Initials

_____ Drug / Alcohol diagnosis, treatment, or referral information
Initials

_____ Genetic testing information
Initials

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral.

Your healthcare and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your healthcare or treatment is for the purpose of creating health information about you to be disclosed to a third party; or for the purpose of research. You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Neighborhood Health Center ATTN: Risk and Compliance, 7320 SW Hunziker Rd, STE 300, Portland, OR 97223, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization and state that you are revoking the Authorization. This Authorization will expire on the earlier of one year from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Signature of Patient or Patient's Legal Representative	*Date*
Print Patient's Name or Name of Patient's Legal Representative	*Relationship to Patient*

OFFICE USE ONLY	
Signature of Staff Member Assisting Patient	*Date*
Title of Staff Member Assisting Patient	