RELEASE OF INFORMATION

7320 SW Hunziker Rd, STE 300, Portland, OR 97223
503-941-3087 | healthrecords@nhcoregon.org

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

For the health information below, I authorize Neighborhood Health Center to (select one):	☐ Get Information From ☐ Give Information To	☐ Get and Give Information From/To
Method of Delivery:	☐ Mail (Paper) ☐ Fax	☐ E-mail ☐ MyChart (only sent to patient)

To and From: (If addresses are not provided, it may delay your request)	*Name of Provider / Individual*		
	Mailing Address, City, State, Zip Code		
	E-mail	*Phone Number*	*Fax Number*

I authorize the sharing of:	☐ Verbal information with the provider/facility/individual above ☐ Past Records ☐ Future Records
For this purpose:	☐ Coordination of Care ☐ Transfer of Care ☐ Personal Use ☐ Insurance / Legal ☐ Other (Explain):
Dates of Service (select one):	☐ Last Visit ☐ Last 2 Years ☐ From (MM/DD/YYYY): To (MM/DD/YYYY):
Requested Information (check all boxes that apply)	☐ Chart Notes (Medical) ☐ X-Ray Reports (Dental) ☐ Chart Notes (Dental) ☐ Other: _____ ☐ Medication List _____ ☐ Immunizations _____ ☐ Laboratory Results _____ ☐ All Health Records
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. _____ *Initials* HIV / AIDS information _____ *Initials* Mental Health Information _____ *Initials* Drug / Alcohol diagnosis, treatment, or referral information _____ *Initials* Genetic Testing Information

RESTRICTIONS: If we already have records from other clinics, it may become part of your chart and may be re-released and not be protected by privacy laws or regulations, except for Alcohol and Drug treatment records we received from a treatment facility or program.

RIGHTS: You do not have to sign this form and you can still get treatment or eligibility for benefits (unless the services are solely for the purpose of giving health information to someone else and your permission is necessary to do that). You may view or copy any information related to this ROI as allowed by Neighborhood Health Center (NHC) policy. NHC has 30 days to process your records request. If you have not received your records, please leave a voicemail at 503-941-3087 or send an e-mail to healthrecords@nhcoregon.org.

CANCELLING THIS FORM: You may cancel this ROI in writing at any time. Any records already sent or received with your permission cannot be undone but we will honor the request to cancel moving forward. To cancel this form, please send a written statement to *Neighborhood Health Center, ATTN: Risk and Compliance, 7320 SW Hunziker Road, STE 300, Portland, OR 97223* and state that you are revoking this authorization. You may also deliver the written notification in person to the nearest NHC clinic.

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The information released in agreement with this authorization may be protected by 45 CFR Part 160 and Subparts A and E or Part 164 and applicable state law (ORS 179.505, 192.525).

I have read this authorization, or it has been read to me. I understand that this authorization begins immediately and remains in effect until my care at NHC ends, or unless I specify a different date or event here:

Date or Event

SIGNATURE	
Signature of Patient or Legal Representative/Guardian	*Date*
Printed Name of Patient or Legal Representative/Guardian	
Relationship to Patient (if not the patient)	

OFFICE USE ONLY

Scan BOTH SIDES of ROI into the patient's record. Note, ROI is incomplete without a valid signature.

- ☐ Form is Complete
- ☐ Identification of Requestor Verified
- ☐ Relationship Verified (if not patient)

Name of NHC Employee Receiving ROI	*Title*
NHC Clinic	