Authorization to Disclose Protected Health Information From The

NCNM CLINICS

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

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

I hereby authorize the NCNM Clinics to disclose my healthcare information to:

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

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

***To disclose my healthcare information from this NCNM Clinic Provider _____ at the following location:**

☐ **NCNM Clinic**
3025 SW Corbett Ave
Portland, OR 97201
Phone: 503.552.1551
Fax: 503.226.8133

☐ **NCNM Community Clinics**
***Clinic:* _____**
049 Porter Street, Portland, OR 97201
Phone: 503.552.1515
Fax: 503.499.0023

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
____ Drug/Alcohol diagnosis, treatment or referral information
____ Mental Health records
____ 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, NCNM Clinics 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!***