NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE

(Formerly Rinehart Clinic)

230 Rowe Street | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | nehalembayhealth.org

Authorization to Release Medical Records

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City, St, Zip: _____

Phone (home): _____ Phone (cell): _____

Please Note: A copying fee may be charged for medical records. Only medical records originating at the Nehalem Bay Health Center will be copied. This authorization is valid only for the release of medical information dated prior to and including the date of this authorization.

Check one:

☐ The above listed person authorizes the *following healthcare facility to disclose* medical records to Nehalem Bay Health Center.

☐ The above listed person authorizes Nehalem Bay Health Center *to disclose* medical records to the following healthcare facility and/or person(s).

Facility/Person's Name: _____ **Phone #:** _____

Facility Address: _____ **Fax #:** _____

City, St, Zip: _____

For the purpose of (check one): Patient Care ☐ Insurance Claim ☐ Self ☐ Other ☐

Dates and Type of information to disclose (check one):

☐ 2 years prior from date last seen ☐ Dates: From: _____ To: _____

Specific Information Requested:

☐ Provider Notes (including Problem List, Allergies and Medications) ☐ Lab Reports ☐ X-Ray Reports

☐ Other: Specify: _____

I understand the information in my health record may include information relating to Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV); Genetic Testing; Behavioral/Mental Health services, and treatment for alcohol and drug abuse.

If you DO wish to share this information, please INITIAL below.

_____ YES, release information pertaining to HIV/AIDS
Initial

_____ YES release information pertaining to Mental/Behavioral Health
Initial

_____ YES, release information pertaining to Genetic Testing
Initial

_____ YES, release information pertaining to Drug/Alcohol Treatment
Initial

I understand that this information may be disclosed to or by the Nehalem Bay Health Center. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and it may not affect my ability to obtain treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This authorization will expire 1 year from the date signed unless otherwise indicated.**

I have reviewed and I understand this authorization.

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative Relationship to Patient