



# NKN STUDENT HEALTH & WELLNESS CENTER

24705 US-101, Rockaway Beach, OR 97136 | Mailing Address: PO Box 176, Wheeler, OR 97147  
Telephone: 503-355-3500 | Fax: 844-720-1901

Rinehart Clinic is the medical sponsor for NKN Student Health & Wellness Center and operates according to the guidelines set forth by Oregon Law (Oregon Revised Statutes: 109.610, 109.640, 109.675, 109.680, ORS 419.112(7), ORS 419C.200(2)). All services will be provided by the Rinehart Clinic health care team.

This Authorization to Release Medical Records is required to be signed by the patient or parent/guardian before medical records are released except, as may be required by law. A student/patient who can legally consent to her/his/their own treatment is authorized to sign this Release. A student/patient who is a minor and requires parental consent to treatment must have the signature of the parent/guardian to authorize release of medical records.

Today's date: \_\_\_\_\_

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

*Please Note:* A copying fee may be charged for medical records. Only medical records originating at the NKN Student Health & Wellness Center and Rinehart Clinic 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 or the patient's parent/guardian authorizes the *following healthcare facility to disclose* medical records to the NKN Student Health & Wellness Center/Rinehart Clinic.
- The above listed person or the patient's parent/guardian authorizes the *NKN Student Health & Wellness Center/Rinehart Clinic to disclose* medical records to the following healthcare facility and/or person(s).

Facility/Person's Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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 (or my child's) 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 substance use disorder (alcohol and drug use).**

**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 NKN Student Health & Wellness Center/Rinehart Clinic. 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.**

X \_\_\_\_\_  
Signature of Patient/Parent/Guardian or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian/Authorized Representative

\_\_\_\_\_  
Relationship to Patient