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

Received by: _____
Entered by: _____

Nehalem Bay Health Center (formerly known as 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 Nehalem Bay Health Center care team.

This authorization to Release of Verbal Medical Information may be signed by the patient or parent/guardian of patients who are minors and require parental consent to treatment.

Today's date: _____

RELEASE OF VERBAL MEDICAL INFORMATION

Patient Name: _____ Birthdate: _____

Due to patient confidentiality laws, Nehalem Bay Health Center does not verbally release any information regarding our patients to anyone other than the patient, parent/guardian as may be required by law, any provider to whom Nehalem Bay Health Center has referred you, or other limited circumstances as may be required by law.

At times, patients or their parents/guardians may wish to have information regarding their or their child's medical condition(s), lab reports, medication, appointment times, etc. discussed with other individuals such as family members or caretakers. If this applies to you, please indicate below any person with whom you would like us to share information regarding your care at the NKN Student Health & Wellness Center/Nehalem Bay Health Center.

Please initial what you would like shared with the person(s) listed below:

_____ I authorize Nehalem Bay Health Center to verbally release information regarding my medical care, including mental health and substance use.

_____ I authorize Nehalem Bay Health Center to verbally release information regarding my financial record.

_____ I authorize Nehalem Bay Health Center to allow appointments to be scheduled on my behalf.

_____ **I Decline** to have any information verbally released by Nehalem Bay Health Center.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____
Patient/Parent/Guardian

_____
Printed Name of Parent/Guardian