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 follows Oregon law (ORS 109.640, 109.675) which permits minors age 15 and older to consent to medical and dental care, and minors 14 and older to consent to outpatient mental health or substance use treatment without a parent or guardian. Minors at any age may sign their own consent to access reproductive health services. While we encourage parental involvement and may notify parents when clinically appropriate (ORS 109.650, 109.680), we also ensure that student health records remain confidential and are only shared with school staff as permitted by law or with specific written authorization.

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