MULTNOMAH COUNTY
HEALTH DEPARTMENT

(THIS FORM MUST BE COMPLETED BEFORE IT IS SIGNED BY THE CLIENT)

Client Name_____ AKA_____
Last First Middle Last First Middle

DOB _____ _____ / _____ _____ / _____ _____ _____ _____ ID#_____

I authorize the Multnomah County Health Department Primary Care Clinic office indicated below:

- ❑ **Westside Health Center (WSHC)**
  426 SW Stark, 5th Floor
  Portland, OR 97204 / 503-988-5140
  FAX 503-988-5180
- ❑ **East County Health Center (ECHC)**
  East County Teen Clinic (ETC)
  600 NE 8th Street, 3rd Floor
  Gresham, OR 97030 / 503-988-5155
  FAX 503-988-5185
- ❑ **La Clínica de Buena Salud**
  6736 NE Killingsworth St., #100
  Portland, OR 97218 / 503-988-3991
  FAX 503-988-3998
- ❑ **Mid-County Health Center (MCHC)**
  12710 SE Division Street
  Portland, OR 97236 / 503-988-3601
  FAX 503-988-3142
- ❑ **North Portland Health Center (NPHC)**
  9000 N Lombard Street
  Portland, OR 97203 / 503-988-5304
  FAX 503-988-5305
- ❑ **Northeast Health Center (NEHC)**
  5329 NE Martin Luther King Jr. Blvd.
  Portland, OR 97211 / 503-988-5183
  FAX 503-988-5182
- ❑ **Health Services Center (HCS)**
  426 SW Stark, 4th Floor
  Portland, OR 97204 / 503-988-5020
  FAX 503-988-5022
- ❑ **X-Ray Services**
  426 SW Stark, 10th Floor
  Portland, OR 97204 / 503-988-3666
  FAX 503-988-5453
- ❑ **Other:** _____
  _____
  _____
  _____
  _____

Multnomah County Health Department Provider: _____

Check appropriate box(es) and give complete name and address:

- ❑ **To give health records to:**
- ❑ **To receive health records from:**
- ❑ **To verbally exchange health information with:**

Name _____
Street Address _____
City _____ State _____ Zip _____

For the purpose of continuing care or:_____

Specific information to be released:_____

By **initialing** the spaces below, I specifically authorize the release of the following health information, if such information exists:

___Drug/alcohol diagnosis, treatment or referral information
___Genetic testing information
___HIV/AIDS related records
___Mental health related information

This authorization will expire in one (1) year or upon (insert date or event)_____ .

I may revoke this authorization in writing by presenting my written revocation to the clinic or site where I received services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

_____ _____ _____
Signature of Client | Date | Interpreter's Signature

_____ _____ _____
Signature of Personal Representative | Date | Relationship to Client

We do not pay for photocopies.

Primary Care Clinics
AUTHORIZATION FOR RELEASE OF INFORMATION