**NATIVE AMERICAN REHABILITATION ASSOCIATION OF THE NORTHWEST, INC.**
**1776 SW Madison St., Portland, OR 97201**

**Authorization to Use / Disclose Health Information**

**Name** (Print clearly): _____ DOB: _____ SS#: _____
First Name Last Name

I hereby authorize **NARA NW** (check one):

| | | | |
|---|---|---|---|
| ☐ Indian Health Clinic | 15 N. Morris, Portland OR 97227 | 503.230.9875 | Fax 503.230.9877 |
| ☐ Outpatient/Outreach | 1631 SW Columbia, Portland OR 97205 | 503.231.2641 | Fax 503.231.1654 |
| ☐ Adult Residential | 17645 NW St. Helens Hwy, Portland OR 97231 | 503.621.1069 | Fax 503.621.0200 |
| ☐ Child & Family/Youth | 620 NE 2nd St., Gresham OR 97030 | 971.274.3757 | Fax 503.912.5741 |
| ☐ Totem Lodge Wellness | 1438 SE Division St, Portland OR 97202 | 503.548.0346 | Fax 503.232.5959 |
| ☐ NARA Wellness Center | 12360 E Burnside St, Portland OR 97233 | 971.279.4800 | Fax 971.279.2051 |
| ☐ Dental Clinic | 12750 SE Stark St., Suite E, Portland OR 97233 | 971.347.3009 | Fax 971.256.3277 |
| ☐ Youth Residential | 620 NE 2nd St., Gresham OR 97030 | 971.274.3757 | Fax 503.912.5740 |
| ☐ Tate Topo/Housing | 1310 SW 17th Ave., Portland, OR 97201 | 503.231.2641 | Fax 503.467.4077 |

☐ to release information to and/or ☐ receive information from

_____ _____
(Person or Organization) (Fax Number)

_____ _____
(Address) (Telephone Number)

This information is in regards to: _____ and expires on _____
(Individual's Name & DOB) (1 year from date unless noted)

**I specifically authorize the release/exchange/receipt of the following (Individual must initial each item):**

___ Identifying Information
___ Lab Reports
___ Physical Exams/Assessments
___ X-ray Reports
___ Discharge Summary
___ Consultation(s)
___ A&D treatment records (If initialed, specific consent below must be signed)
___ Mental Health treatment records (If initialed, specific consent below must be signed)
___ HIV Antibody test and results (If initialed, specific consent below must be signed)
___ Psychiatric Evaluation(s)
___ Physician Orders
___ Progress Notes
___ All of my substance use disorder records
___ Other _____

**This information is needed for the following purpose(s):**

☐ Diagnosis and Evaluation
☐ Treatment Planning
☐ Facilitate Changing Physicians/Clinics
☐ Facilitate Insurance/Billing
☐ Referral/Consultation
☐ Coordinate Aftercare/Ongoing Treatment/Services
☐ Other _____

I understand that I may revoke this authorization in writing submitted at any time to the location checked above, except to the extent that action had been taken in reliance on this authorization.

I understand that NARA NW will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal law. I understand I may request a list of locations/individuals that my records have been disclosed to.

| | |
|---|---|
| Signature of Individual: | Date: |
| Signature of Authorized Representative (State relationship to individual) or Witness (if signature is mark.) | Date: |

| | | |
|---|---|---|
| I recognize that the information released may contain drug/alcohol information that is protected by federal and state law. (42CFR2.31, ORS 430.399(5) & 179.505) I specifically consent to its release.<br>X _____<br>Signature<br>X _____<br>Date | I recognize that the information released may contain information regarding HIV/AIDS testing, treatment, or high-risk behavior. (OAR 333-012-0270, ORS 433.045). I specifically consent to its release.<br>X _____<br>Signature<br>X _____<br>Date | I recognize that the information released may contain information regarding mental health treatment that is protected by state law (ORS 179.505 & 192.505, 45 CFR 205.50) I specifically consent to its release.<br>X _____<br>Signature<br>X _____<br>Date |



**A photo static copy of this authorization shall be considered as effective and valid as the original.**

This is the Release of Information (ROI) you requested. It must be filled out completely in order for us to release the records.

- On the Name line: Please print your name, date of birth and social security number.

- Under the listed NARA locations: Please check the appropriate box for us to release or receive your health information.

- Following the release/receive check boxes: Please list the full name (or business name), address, phone and fax number (if available) of the person or facility that will either send or receive your health information.

- After writing the person/business information: Use the "This information is in regards to:" line if you are completing the form for a dependent. List the name and date of birth of the dependent. This release will be valid for one (1) year. If you want the release is to be valid for more or less than one year, please fill in a date.

- Under "I specifically authorize….": You must **initial** the specific items to be released. If you initial for A & D treatment, Mental Health or HIV Antibody tests/results records to be released, you must sign and date the corresponding boxes at the bottom of the page.

- Under "This information is needed…:" Please check the appropriate box(es) indicating the reason for the release of your health information.

- Finally, please sign and date the form as listed.



**A photo static copy of this authorization shall be considered as effective and valid as the original.**