Sunrise Family Clinic & McMinnville SBHC
Jacqui Terrill Cooke, FNP, CNM, Noelle McLaughlin, DNP
Lisa Bingham, FNP, Tracy Brunette, FNP
320 SE Baker St., McMinnville, OR 97128
SBHC: 1500 NE Baker St., McMinnville, OR 97128
Phone: (503) 474-3600/Fax: (503) 474-3601
www.sunrisefamilyclinic.com

1. Patient Name: _____ Maiden/former Name: _____
   Birth Date: _____ Contact Phone: _____

2. I authorize the following organization(s): _____
   _____ _____
   _____ _____
   _____ _____

3. To: ☐ Release information to ☐ Release information *from* ☐ Exchange information with:

   Sunrise Family Clinic and/or McMinnville School Based Health Center (SBHC)
   Mailing Address: 320 SE Baker St., McMinnville, OR 97128 Phone: 503-474-3600
   Fax: 503-474-3601

4. Extent or nature of records and information to be released:

☐ All records (medical history, including chart notes, laboratory and imaging results, consultation reports, etc.)
☐ Admission histories and physicals, discharge summaries, and all laboratory and imaging results
☐ McMinnville SBHC primary care provider specific request: Problem list, medication list, last physical exam, comprehensive health evaluations, labs, and any other information deemed applicable to coordination of care **(THIS IS NOT A TRANSFER OF CARE REQUEST)**
☐ McMinnville SBHC school specific request: Any educational, counseling, and health records applicable to student's health status, including, but not limited to, school nurse notes, immunization records, IEP and 504 plan information
☐ Specific hospitalization(s) or visit(s) dated: _____
☐ Other (specify)_____
_____

5. I understand and agree that the following sensitive information below will be disclosed if I place my initials in the applicable space next to the type of information.

____ HIV/AIDS testing/treatment	____ Mental Health	Includes psychological and/or psychiatric records, not limited to assessment, evaluation, diagnosis, care/treatment plan or summary, medication management information
____ Genetic Testing	____ Drug/Alcohol	

Purpose of disclosure: ☐ Continuity of Care ☐ Transfer of care
☐ Other:_____

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6. **Notices:**

   a. Coordination of Care: I understand that this release is to help give me the best possible holistic care.

   b. **Revocation:** I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Sunrise Family Clinic, 320 SE Baker St., McMinnville, OR 97128. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

   c. **Expiration:** Unless sooner revoked, this authorization expires 12 months following the date of signature or on the following date: _____

   d. **Conditions:** I understand that I do not have to give permission to share my information with the person(s) or organization(s) listed. I have the right to refuse to sign this form for authorization to disclose or release my protected health information. I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or treatments or to pay for the services received. Refusal to sign the authorization will not otherwise adversely affect my ability to receive health care services or reimbursement for services.

   e. **Form of Disclosure:** Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

   f. **Redisclosure:** Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law restricts re-disclosure of HIV/ AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

   g. Fees: I understand there may be a fee associated with this request.

   h. Copies: Upon request, I will be given a copy of this disclosure for my records. A photocopy is as valid as the original.

   i. School specific: I understand that some of my records may be protected under the Family Educational Rights and Privacy Act of 1974 and cannot be released without my written consent. I hereby waive all provisions of the law and privilege relating to the records described in this disclosure. The person and or agency receiving this information may not redisclose school information received as a result of this disclosure unless specifically authorized in the “purpose” section of this release.

Signature of Patient/Guardian: _____ Date: _____

Relationship to patient if unable to sign: _____