NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE

Received by: _____
Entered by: _____

885 Nehalem Blvd | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | Nehalembayhealth.org

Release of Verbal Health Information

Patient Name: _____DOB: _____

Due to patient confidentiality laws, Nehalem Bay Health Center does not verbally release any information regarding our patients to anyone other than the patient, or any physician to whom Nehalem Bay Health Center has referred you.

At times, patients may wish to have information regarding their health 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 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.

Note: Any updates to this information, i.e. removing authorizations, will need to be made by completing a new Release of Information. **This form is only valid for one year, after one year, this form will need to be completed again, regardless of any changes.**

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____