Personal Health Information (PHI) Consent Form

Your privacy is our most important goal. Federal law requires that your information may not be shared with anyone, unless law allows it or permission has been given.

Northwest Research Center, an affiliate of Northwest Primary Care, may have access to and share your Protected Health Information to determine your eligibility for potential clinical trial participation. If you would like to restrict your information from Northwest Research Center, you must opt-out by signing here. X ______________________________

Please note: Anyone listed below as having permission to have access to your Protected Health Information (whether on paper, electronic, or verbal) will have access that may include specially protected records (i.e. HIV results) ORS 333-022-0210.

I, __________________________, DOB ________________ authorize the following person(s) to discuss, receive written documents and/or have access to My NWPC Chart with all my personal health information (PHI), which consists of Billing/Insurance, Appointments, and all Health Information and Treatments.

Check here if you are choosing, **none:** ☐

1) ____________________ Relationship: ____________________ Phone: ____________________

2) ____________________ Relationship: ____________________ Phone: ____________________

3) ____________________ Relationship: ____________________ Phone: ____________________

4) ____________________ Relationship: ____________________ Phone: ____________________

NWPC normally will not leave detailed voice mail messages due to HIPAA concerns, unless:

○ I also authorize NWPC to leave a detailed message on the phone number(s) listed below.

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Patient Signature: ______________________________________ Date: ____________________

My Health Record email address:

****If at any time you wish to rescind your consent, you must update this consent form at one of our clinics. This form is updated annually and will replace all previous PHI consent forms.****

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