



**FANNO CREEK**  
C L I N I C

Dear \_\_\_\_\_:

Welcome to Fanno Creek Clinic and thank you for choosing us for your healthcare needs. Your appointment with \_\_\_\_\_ is on \_\_\_\_\_ at \_\_\_\_\_. Please arrive 15-20 minutes early for your first appointment to complete the check-in process. This initial visit will be to establish care. If you have multiple medical concerns or need a physical exam, you may be asked to schedule a subsequent appointment.

Enclosed you will find information for your review. Be sure to bring the completed health forms to your initial appointment, along with your insurance card. For security and confidentiality reasons, we will ask you for photo identification.

If your insurance company requires you to name a primary care provider, please make sure you have notified them of your new provider. If insurance coverage cannot be verified prior to your appointment, a \$100 deposit will be required at the time you check in for that visit. If you have concerns regarding this matter, please feel free to contact our Clinic Administrator, Lane Hickey, ext. 163.

Please note that Fanno Creek Clinic maintains a cancellation and reschedule policy that requires 24 hours notice. Unfortunately, if you fail to provide the required notice more than once, future appointments may not be scheduled. Once established as a patient, failure to provide 24 hours notice 3 times may result in dismissal from the clinic.

For your convenience, directions to our clinic are included in this packet. If you have any questions, please contact our office at (503) 452-0915 or visit us online at [www.fannocreek.com](http://www.fannocreek.com). We look forward to seeing you!

Sincerely,

Fanno Creek Clinic Staff

**Fanno Creek Clinic**  
**2400 SW Vermont St.**  
**Portland, Oregon 97219**  
**(503) 452-0915**  
**Fax: (503) 768-9232**



## **Fanno Creek Clinic: General Information**

**Clinic Hours:** The clinic is open from 8:00 am until 5:00 pm Monday - Friday.

**Emergencies:** Dial 911 for life threatening emergencies. During business hours call the clinic and your Doctor or a Nurse will assist you. After hours (5:00 pm – 8:00 am and weekends) you may reach the Doctor on call by calling the clinic and choosing option 2. Leave a message and the Doctor will be paged immediately.

**Prescription Refills:** Please allow 72 hours (3-5 days) for your prescriptions to be refilled. No narcotics will be refilled after 5:00 pm. Approximately one week before you will be running out, have your pharmacy fax us a request to refill it. Your pharmacist will be able to answer many questions you may have regarding your medication. The fax number is (503) 892-9875.

**Same Day Appointments:** All requests for appointments the same day you call will be triaged through a Nurse. Although the receptionists cannot make these appointments without authorization from the Doctor or a Nurse, they can make you an appointment for the next available opening.

**Lab Hours:** The clinic lab is open from 7:30 am until 4:45 pm, Monday – Friday. You need to check in at the reception desk to pick up your lab order form. Check with your insurance for coverage.

**Medical Record Transfers:** You will need to complete a release of information form before records can be sent or received. You can come into the clinic and fill out the form or you can go to the clinic your records are at (if they are not here) and sign a release there. Please allow approximately 2 weeks for the transfer.

## DIRECTIONS TO FANNO CREEK CLINIC

Fanno Creek Clinic is located at **2400 SW Vermont St**, Portland, Oregon 97219. Free parking is available in the parking lot directly in front of the building, offering easy access for our patients.

**TRIMET INFORMATION:** TriMet bus numbers 1, 44, and 45 stop near our clinic. For further information contact TriMet at 503-238-7433 or visit the web site at: <http://www.trimet.org/>.

### FROM THE EAST:

1. Starting out from **I-84 W/US-30 W**, merge onto **I-5 South** via the exit on the left toward Beaverton-Salem.
2. Take **Exit 297** toward **Terwilliger Blvd**.
3. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
4. Go **straight** at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
5. Go to the second traffic light and turn **left** onto **Vermont St**.
6. **2400 SW Vermont St** is at the top of the hill on the left.

### FROM THE SOUTH:

1. Start out going **north** on **I-5**.
2. Take **Exit 297**. Get into the right lane to avoid getting back on the freeway.
3. Turn **left** at the traffic light onto **Terwilliger Blvd**.
4. Stay in the left lane and turn **left** onto **SW Barbur Blvd/OR-99 W/Pacific Hwy W**.
5. Get into far right lane and turn **right** onto **SW Bertha Blvd** (just before Fred Meyer).
6. Go to the second traffic light and turn **left** onto **Vermont St**.
7. **2400 SW Vermont St** is at the top of the hill on the left.

### FROM THE NORTH:

1. Start out going **south** on **I-5**.
2. Take **Exit 297** toward **Terwilliger Blvd**.
3. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
4. Go straight at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
5. Go to the second traffic light and turn **left** onto **Vermont St**.
6. **2400 SW Vermont St** is at the top of the hill on the left.

### FROM THE WEST:

1. Start out going **east** on **Sunset Hwy/26**.
2. Take the **405 South Exit**.
3. Merge onto **I-5 South** via the exit on the **left**.
4. Take **Exit 297** toward **Terwilliger Blvd**.
5. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
6. Go **straight** at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
7. Go to the second traffic light and turn **left** onto **Vermont St**.
8. **2400 SW Vermont St** is at the top of the hill on the left.

### OR:

1. Start out going **east** on **Beaverton-Hillsdale Hwy**.
2. Turn **right** onto **30<sup>th</sup> Ave**.
3. Turn **left** at the light onto **Capitol Hwy/Vermont St**.
4. Turn **right** to stay on **SW Vermont**.
5. **2400 SW Vermont St** will be on your right.

# FANNO CREEK CLINIC

## Adult Health Questionnaire

**GENERAL INFORMATION:** Completed by patient, please print:

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Emergency Contact Person: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_  
 Marital Status: S  M  W  D  Sep  Partner  Live With: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_  
 Current Concerns: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL HISTORY:** Check current or past problems, indicating date of onset:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Glaucoma _____                  | <input type="checkbox"/> Emphysema _____                    | <input type="checkbox"/> Arthritis _____          |
| <input type="checkbox"/> Cataracts _____                 | <input type="checkbox"/> Asthma _____                       | <input type="checkbox"/> Decreased Hearing _____  |
| <input type="checkbox"/> Tuberculosis/TB _____           | <input type="checkbox"/> Seizures _____                     | <input type="checkbox"/> Anemia _____             |
| <input type="checkbox"/> Diabetes _____                  | <input type="checkbox"/> Ulcer _____                        | <input type="checkbox"/> Emotional Problems _____ |
| <input type="checkbox"/> Thyroid Problems _____          | <input type="checkbox"/> Hepatitis _____                    | <input type="checkbox"/> Depression _____         |
| <input type="checkbox"/> High Blood Pressure _____       | <input type="checkbox"/> Liver Problems _____               | <input type="checkbox"/> Cancer (type) _____      |
| <input type="checkbox"/> Heart Trouble/Angina _____      | <input type="checkbox"/> Kidney Problems _____              | <input type="checkbox"/> Heart Attack _____       |
| <input type="checkbox"/> Bladder Problems _____          | <input type="checkbox"/> HIV/AIDS _____                     | <input type="checkbox"/> Stroke _____             |
| <input type="checkbox"/> High Cholesterol _____          | <input type="checkbox"/> Blood Clotting _____               |   |
| <input type="checkbox"/> Broken Bones/Osteoporosis _____ | <input type="checkbox"/> Sexually Transmitted Disease _____ |   |
| <input type="checkbox"/> Other _____                     |   |   |

**SURGICAL HISTORY:** Check type of surgery and date of procedure:

- Appendectomy \_\_\_\_\_  Cataract Surgery \_\_\_\_\_  Prostate Surgery \_\_\_\_\_  
 Hysterectomy (Full: uterus & ovaries) \_\_\_\_\_  (Partial: uterus only) \_\_\_\_\_  
 Other: \_\_\_\_\_

**OTHER HOSPITALIZATIONS:** Reason & Date: \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS:** List all medications you are now taking, indicate over-the-counter medications, vitamins & supplements, continue on back if needed:

<u>Name</u>	<u>Strength</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**DRUG ALLERGIES:** Please list all known drug allergies:

\_\_\_\_\_  
 \_\_\_\_\_

**HEALTH HABITS:** Indicate all that apply:

**Diet:** Regular  Fast Foods  Low Fat  Low Salt  Vegetarian

**Tobacco:** Never Smoked  Smoked  From \_\_\_ to \_\_\_ Packs/Day Current  Packs/Day \_\_\_

**Alcohol:** Never  Occasionally  Regularly  Drinks/Day \_\_\_ Heavy  In Past  Quit \_\_\_

**Street Drugs:** Never  Occasionally  In Past  Type \_\_\_\_\_ Injection Use: Y  N

**Sexually Active:** Not Active  Monogamous  Multiple Partners  Safe Sex: Y  N

**Exercise:** Unable  Rarely  Occasionally  Regularly  Type(s): \_\_\_\_\_

**Seatbelt Use:** Never  Sometimes  Always  Automatic  Firearms In Home: Y  N

**FAMILY MEDICAL HISTORY:** Indicate health problems & cause of death where applicable. Specify types of cancer, heart disease, diabetes, etc.

<u>MEMBER</u>	<u>LIVING</u>	<u>AGE</u>	<u>MEDICAL INFORMATION</u>
Mother	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Father	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Bro/Sis	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Bro/Sis	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Bro/Sis	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____

**CURRENT HEALTH CONCERNS:** Check all recent problems:

- |   |                                       |   |   |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Weight Loss    | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Joint Swelling     | <input type="checkbox"/> Fevers                   |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Chills       | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Leg Pain (while walking) |
| <input type="checkbox"/> Hearing Loss   | <input type="checkbox"/> Heartburn    | <input type="checkbox"/> Rash/Itching       | <input type="checkbox"/> Easy Bruising/Bleeding   |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Cough              | <input type="checkbox"/> Shortness of Breath      |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Fainting Spells    | <input type="checkbox"/> Bloody/Tarry Stools      |
| <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Painful Urination        |
| <input type="checkbox"/> Palpitations   | <input type="checkbox"/> Anxiety      | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Vaginal/Penile Discharge |
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Joint Pain   | <input type="checkbox"/> Poor Appetite      | <input type="checkbox"/> Sexual Problems          |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Other: _____ |   |   |

**IMMUNIZATIONS:** Please check with date:

Tetanus \_\_\_\_\_  Hepatitis \_\_\_\_\_  Pneumovax \_\_\_\_\_  Other \_\_\_\_\_

**WOMEN'S HEALTH:** Please complete:

Last Pap Test: \_\_\_ Normal: Y  N  Last Mammogram: \_\_\_ Normal: Y  N

Menstrual History: Age of Onset: \_\_\_ Regular: Y  N  Last Menstrual Period: \_\_\_

Number of Pregnancies: \_\_\_ Number of Live Births: \_\_\_ Number of Miscarriages: \_\_\_

Current Birth Control Method: \_\_\_\_\_ Date of Menopause: \_\_\_

# Fanno Creek Clinic, LLC Financial Policy

The most important and singular goal at Fanno Creek Clinic is to provide you, our patient, with the best and current 'state-of-the-art' medical care available, in a friendly, positive and supportive environment.

The following information outlines your financial responsibilities related to payment for professional services and testing, as you, the patient, are ultimately responsible for all charges associated with your care regardless of insurance coverage. These include, but are not necessarily limited to, ancillary testing, like Laboratory tests and x-ray assisted diagnoses, that your provider deems medically necessary for accurate diagnosis. Fanno Creek Providers believe that a good provider/patient relationship is based on understanding and communication regarding these financial responsibilities.

### Patient Responsibilities

- Patients are responsible for all fees at the time of service including co-pays. A \$10.00 billing fee will be assessed if your co-pay is not received at the time of service.
- Patients are responsible for providing a current insurance card that has your name and claim submission information. Patients who do not provide insurance information at time of service may be responsible for all charges associated with the visit.
- Patients are responsible for providing Fanno Creek Clinic with up-to date address and other contact information.
- Patients must obtain a referral for outside services. If you choose to be seen at a specialist's office, urgent care clinic, or hospital prior to obtaining valid authorization your visit may not be covered.
- If you have an insurance plan that Fanno Creek Clinic does not participate with we will file a claim for you as a courtesy. However, if payment is not received within 60 days of filing any remaining balance will become patient responsibility and will be due immediately.
- Patients who do not show up for an appointment or cancel an appointment with less than 24 hour notice (by the end of the prior business day) may be assessed a \$25.00 fee for each missed visit. Three no-shows and/or same day cancellations may result in dismissal from Fanno Creek Clinic.
- All payments are due within 30 days from the date of Fanno Creek Clinic's initial billing statement.
- Insured patients with an unmet deductible of \$500.00 or more who are not currently established with Fanno Creek Clinic (greater than 12 months since the last visit) will be required to pay a \$100.00 deposit for any office visit.
- Uninsured patients and patients with out-of-network benefits will be required to pay a deposit of \$100.00 for all office visits. All services rendered are patient responsibility and due at time of service.
- Payment plans are available for established patients. Please contact our business office prior to your appointment if you anticipate a need for financial assistance at (503)452-0915, option 5.
- If an account becomes delinquent, it may be assigned to an outside collection agency. Patients are responsible

**Psychiatric appointments:** *Our psychiatrists require that patients provide, at least two weeks in advance, a deposit of \$150.00 (by check or cash). This helps reserve the appointment with your psychiatrist. This deposit is refundable if cancellation notice is given to the clinic or your psychiatrist at least 48 hours prior to your appointment.*

### Insurance Billing

**Medicare:** Our physicians and specialists are Medicare participating providers and we will bill Medicare as your primary insurance. In some cases Medicare may automatically forward the bill to your secondary insurance. We require you to provide us up-to-date secondary insurance information to ensure payment is made in a timely fashion.

**Secondary insurance:** Fanno Creek Clinic will bill your secondary insurance provided the information is provided up front to ensure timely filing with insurance companies. If insurance information is not provided at time of service you may be responsible for all charges associated with your visit.

**Motor Vehicle Accident/Liability Claims:** Please notify the front desk when you check in if your appointment is related to an auto, work, or liability claim and provide billing information, including your claim number, prior to being seen. Fanno Creek Clinic requires a \$100.00 deposit for all visits related to a motor vehicle accident or liability claim. Any balance remaining is the patient's responsibility.

### Agreement

I understand that I, the patient, am ultimately responsible for all charges associated with my visit including, but not limited to, all ancillary charges (lab and x-ray) deemed medically necessary for accurate diagnosis and treatment, including charges from external facilities associated with services provided at Fanno Creek Clinic. My signature below indicates I have read and understand this financial policy and agree to abide by its terms for my treatment at Fanno Creek Clinic, LLC.

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Patient Signature (parent/guardian signature if patient is a minor)

Date

---

Printed Name

Date of Birth



**FANNO CREEK**  
CLINIC

**2400 SW Vermont St.  
Portland, Oregon 97219  
(503) 452-0915**

**NOTICE: PATIENT PRIVACY**

*August 24, 2016*

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medical information and to provide you with notice describing:

**HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND  
HOW YOU CAN ACCESS THIS INFORMATION.**

Fanno Creek Clinic may use and disclose the following information without your authorization for the purpose of and relating to: Treatment, Payment, Health Care Operations, Appointments, Treatment Alternatives, Health-related Products and Services, and the following situations: safety; required by law; research; organ and tissue donation; military veterans; national security and intelligence; workers' compensation; public health risks; health oversight activities; lawsuits and disputes; law enforcement; coroners; medical examiners and funeral directors; and information not personally identifiable. Detailed descriptions of the purposes and situations (not all situations will be described) can be found in our current Privacy Notice. The Clinic requests that you sign below as written acknowledgement of this Notice is required.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice of Privacy Practices from time to time. The effective date at the top of this page indicates the date of the most current Notice of Privacy Practices in effect.
- You have the right to receive a copy of our most current notice in effect. If you would like to request a copy, please ask at the front desk.
- If you have any questions, concerns or complaints about this notice or your medical information, please contact Lane Hickey, Clinic Administrator, at 503-452-0915 x 163.

\_\_\_\_\_  
**Patient Signature:**

\_\_\_\_\_  
**Date of Birth:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Print Patient Name:**





**FANNO CREEK**  
CLINIC

**CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION**

The Health Insurance Portability and Accountability Act (HIPAA) restricts Fanno Creek Clinic and its employees from releasing protected health information to any individual other than the patient unless the patient indicates consent in writing. If you wish to designate someone other than yourself with whom we may discuss your medical information, diagnostic or laboratory results, and/or financial information please indicate their name, relationship, and contact phone number below:

NAME	RELATIONSHIP	PHONE

By signing below, I, \_\_\_\_\_, authorize Fanno Creek Clinic to release medical information and/or financial information related to my care to the above named individuals. I understand that I may revoke and/or update this authorization at any time by notifying Fanno Creek Clinic in writing.

\_\_\_\_\_  
Signature of patient/authorized representative

\_\_\_\_\_  
Patient's date of birth

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date



**FANNO CREEK**  
C L I N I C

**CONSENT TO LEAVE PERSONAL HEALTH INFORMATION BY VOICEMAIL**

**Please check one of the following:**

- I give my consent to Fanno Creek Clinic physicians and staff to leave detailed voicemail messages regarding my medical information, diagnostic or laboratory results, and/or financial information at the following phone numbers:

My Home: (    ) \_\_\_\_\_ My Cell: (    ) \_\_\_\_\_

- I **do not** consent to receiving detailed voicemail messages regarding my medical information at home, on my cell phone, or at any other number.

\_\_\_\_\_  
Signature of patient/authorized representative

\_\_\_\_\_  
Patient's date of birth

\_\_\_\_\_  
Print patient name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

## How did you hear about Fanno Creek Clinic?

Dear Patient,

Welcome to Fanno Creek Clinic! We appreciate you choosing us for your healthcare. Please let us know how you found us.

Have you been a prior patient of one of our Providers at a different location? Y  N   
If so, which Provider? \_\_\_\_\_

How Did You Hear About Us? Please Check All That Apply:

- Recommendation from Friend**
- Recommendation from Family Member**
- Advertisement**                      **Publication Name:** \_\_\_\_\_
- Yellow Pages**
- News Story**                              **Publication/Outlet:** \_\_\_\_\_
- Did a Physician refer you?**      **Physician Name:** \_\_\_\_\_
- Insurance List/Referral**
- Website**
- Clinic Sign**
- Promotional Mailing**
- Zocdoc**
- Other; Please Specify:** \_\_\_\_\_

Comments or Suggestions:

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Thank you for taking the time to fill out this form. Please return it to the receptionist.

Sincerely,

Gregg Coodley, MD



# Fanno Creek Clinic

## Patient Portal User Agreement

Fanno Creek Clinic, (FCC) is pleased to provide you the ability to access parts of your personal medical record by using our Patient Portal Program, (the Patient Portal). By requesting access and set up of a Patient Portal account, you agree to the following terms and conditions:

### **ELIGIBILITY**

In order to participate in the Patient Portal, you must be at least 18 years of age, and an active patient of an FCC physician.

### **USE OF PATIENT PORTAL**

By requesting participation in the Patient Portal, you understand and agree to the following:

- a) The Patient Portal is intended as a secure, online means for you to access a limited portion of your personal and confidential medical record.
- b) The Patient Portal is not meant to be used in any manner during an emergency. In any emergency situation, you should immediately seek appropriate emergency care.
- c) You will use the Patient Portal only as permitted, and not attempt to harm or circumvent any of its security features, or use the Patient Portal for any purpose other than as described in this agreement.
- d) The Patient Portal provides access to a limited portion of your medical record. It does not provide access to your complete medical record.
- e) The Patient Portal is voluntary; you are not required to use the Patient Portal to receive care from FCC providers. FCC will not condition your treatment or care based on your participation in the Patient Portal.
- f) If you wish to discontinue use of the Patient Portal you should contact FCC immediately.

### **PROVISION OF SERVICES**

- a) The Patient Portal is being provided as a convenience to our valued patients. FCC will attempt to provide access to the Patient Portal without interruption, but access is provided on an "as is available" basis.
- b) FCC cannot guarantee that the Patient Portal will be error-free. Should you have reason to believe that your information contained in the Patient Portal is incorrect, or that there is an error within the Patient Portal, please contact FCC immediately.
- c) FCC has the right to terminate your Patient Portal access at any time for any reason. If abuse or negligent use of the Patient Portal occurs, we reserve the right at our own discretion to terminate the Patient Portal offering, suspend user access, or modify services or terms of services offered through the Patient Portal.
- d) You agree that FCC takes no responsibility for, and disclaims any and all liability arising from any inaccuracies or defects in the information, software, communication lines, Internet, or your Internet Service Provider (ISP), computer hardware or software, or any other service or device that you use to access the Patient Portal.

### **PRIVACY POLICY**

FCC is fully committed to complying with all federal and state laws and regulations concerning the confidentiality of medical record information. Our HIPAA Notice of Privacy Practices can be found at:

[http://fannocreek.com/media/images/patient\\_forms/privacy.pdf](http://fannocreek.com/media/images/patient_forms/privacy.pdf)

**SECURITY**

*IMPORTANT: There are certain risks associated with the use of the Internet to access your personal medical information and you acknowledge that you have been advised of these risks. If you have any concerns regarding the security of your information or the use of the Internet to access your medical record information through the Patient Portal, you should consider not creating a Patient Portal account.*

- a) The Patient Portal is provided in partnership with our Electronic Medical Records (EMR) software vendor and other providers. All Patient Portal data is stored at FCC and is on HIPAA-compliant servers with high level encryption.
- b) You should not access the Patient Portal from a public computer or from an unsecured wireless network.
- c) You should take steps to ensure that your computer or connecting device is secure and free of malware and/or viruses, and has the latest security updates.
- d) You must keep all information (credentials) used to connect to the Patient Portal confidential and secure. If you believe or suspect that the confidentiality of your username, password, or secret questions have been compromised, you should change your password immediately by following the procedures described in the Patient Portal.
- e) FCC is not responsible for any breach of your confidential medical record information due to your sharing or losing your user name, password, or the answers to your security questions.

FCC may modify these terms and conditions, other terms and materials referenced in this document, the Patient Portal, or the content of the Patient Portal website at any time. For this reason, you should review these terms and conditions on the website periodically.

*I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online access of my personal medical record, and consent to the conditions outlined herein. These terms and conditions are governed by and will be interpreted in accordance with the laws of the State of Oregon.*

_____	_____
<b>PATIENT NAME (PRINT)</b>	<b>DATE OF BIRTH</b>
_____	
<b>SIGNATURE / DATE</b>	

**FANNO CREEK CLINIC, LLC.**

2400 SW Vermont St. Portland, Oregon 97219

Phone: (503) 452-0915 Fax: (503) 768-9232

**MEDICAL AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

~PLEASE PRINT~

I, (patient's name): \_\_\_\_\_ DOB: \_\_\_\_\_

authorize the disclosure of my health information as identified below:

**FROM:** [provider's name/ address]:

\_\_\_\_\_

**TO:** [recipient's name/address]: \_\_\_\_\_

for the following purpose (s) **[please initial]** : Change of provider \_\_\_\_\_ Continuity of care \_\_\_\_\_

"At the request of the patient" \_\_\_\_\_ or Other (describe initial): \_\_\_\_\_

By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and records:

\_\_\_\_\_ Entire medical record (all information)

\_\_\_\_\_ Billing record

\_\_\_\_\_ Medical records developed from \_\_\_\_\_ to \_\_\_\_\_ [start date/end date]

\_\_\_\_\_ **\*\*other [specify]:** \_\_\_\_\_

**\*\*If the information to be used or disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information may apply. I agree the following categories must be initialed to be included in this authorization to release information:**

\_\_\_\_\_ **\*\*HIV/AIDS related health information/records**

\_\_\_\_\_ **\*\*Mental health information/records**

\_\_\_\_\_ **\*\*Genetic testing information/records**

\_\_\_\_\_ **\*\*Drug/alcohol diagnosis, treatment and/or referral information.** [Federal law prohibits the re-disclosure of this health information.] Federal law requires that a description of the kind of information and how much, be included in this request: \_\_\_\_\_

\_\_\_\_\_ **\*\*\*Psychotherapy notes** [If authorization is for the disclosure of psychotherapy notes, it cannot be combined with any other authorization.]

**\*\*\*REQUIRED:** Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. **Unless revoked earlier, this authorization will terminate on: \*\*\* \_\_\_\_\_ \*\*\*.**

I understand I may inspect or copy any information disclosed under this authorization unless otherwise restricted by law.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I understand that the person{s} I am authorizing to use or disclose my information may receive compensation for doing so.

\_\_\_\_\_  
(Signature of Individual or legal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Individual)

[A copy of this signed form will be provided to the individual and/or the individual's legal representative]