COLUMBIA RIVER HEALTH

PO Box 397 ● 450 Tatone Street, Boardman, OR 97818 ● 541-481-7212 ● www.crhclinic.net

ACKNOWLEDGE AND AUTHORIZATION

- I have read and understand the HIPAA/Privacy Policy for Columbia River Health.

Signed: _____Date: _____

Please initial the following and sign below

- I hereby assign my insurance benefits to be paid directly to the healthcare provider._____
- I have read and understand the Payment Consent Form/Consent to Treat for Columbia River Health._____
- I authorize Columbia River Health to obtain/have access to my medication history._____
- I authorize my provider's office to contact me by mobile phone._____
- I authorize my provider's office to release any vaccination/immunization information to the State of Oregon's ALERT system._____

I have read and understand the above statements.

Signed: _____ Date: _____

FOR STAFF USE ONLY

Patient ID: _____

Patient Name: _____

Patient DOB: _____