



Pediatric Associates  
of the Northwest, P.C.

**Authorization to Release Medical Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone Number \_\_\_\_\_

I authorize Pediatric Associates of the Northwest, P.C.

4103 SW Mercantile Drive  
Lake Oswego, OR 97035  
Phone 503-636-4508 Fax 503-635-3729

2525 Lovejoy, Suite 200  
Portland, Oregon 97210  
Phone 503-227-0671 Fax 503-227-0676

To release medical records to:

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

Purpose of Release ( Please check appropriate box)

- Changing primary care physician/clinic
- Other (Please list) \_\_\_\_\_

Type of information to be released

- GENERAL Medical Records –excluding protected records: (Copies of medical records will be limited to two years of information including lab, x-ray unless otherwise requested.)
- SPECIFIC Information only:
  - History & Physical –specify date \_\_\_\_\_
  - Medications/Therapy \_\_\_\_\_
  - Lab, Path, EKG, X-Ray—Specify Type \_\_\_\_\_
  - Operative report – type of operation \_\_\_\_\_
  - Accident or injury—Dates from \_\_\_\_\_ to \_\_\_\_\_
  - Immunizations \_\_\_\_\_
  - Other \_\_\_\_\_

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. By INITIALING I authorize the release of the following protected or sensitive information:

\_\_\_\_\_ Drug Abuse Diagnosis/Treatment \_\_\_\_\_ Sexually Transmitted Diseases  
\_\_\_\_\_ Alcoholism Diagnosis/Treatment \_\_\_\_\_ Mental Health Treatment  
\_\_\_\_\_ AIDS/HIV Test results including related High Risk behaviors  
\_\_\_\_\_ Genetic Testing

Patient Authorization to Release Information

Signature of Patient or Legally Responsible Person \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

*This authorization is valid for 90 days and may be revoked by the patient (orally and in writing) at any time prior to the 90 days.*