



Pediatric Associates
of the Northwest, P.C.

Authorization to Release Medical Information

Patient Name _____ Date of Birth _____

Phone Number _____

I authorize information to be released from:

Name of Facility _____ Name of Physician _____

Address: _____ City _____ State _____ Zip _____

Please Send My Records To:

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

Attn: Dr. _____

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.