pediatric associates OF THE NORTHWEST

Authorization to Release Medical Information from Pediatric Associates

Patient Name _____ **Date of Birth** _____ **Phone Number** _____

I authorize Pediatric Associates of the Northwest, P.C. to release general medical records/information to (for protected information inclusion, see below)**:**

Name/Address: _____

_____

Telephone: _____ **Fax:** _____

Purpose of disclosure (Please check appropriate box):

☐ Personal Use** ☐ Outside referral ☐ Changing primary care physician/clinic ☐ Verbal Communication

☐ Legal** ☐ School ☐ Coordination of Care

☐ Other (specify)_____

**** There is a charge to copy for personal use and legal purposes. Charges are waived when sent to another provider.**

Type of information to be released:

☐ GENERAL medical records –**excluding** protected records: (see below)

Records will be limited to two years of information including labs and x-rays unless otherwise requested

☐ SPECIFIC information only: _____

_____

_____

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:

_____ AIDS/HIV Test Results _____ Genetic Testing

_____ Alcoholism/Drug Abuse Treatment _____ Mental Health Diagnosis/Treatment (including ADD/ADHD)

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and authorization is necessary to participate in the research study and receive research related treatment.

This authorization is valid for ***one year*** and may be revoked by the patient (orally and in writing) at any time prior to ***one year***. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot
be undone. To revoke this authorization, please send a written statement to Medical Records at Pediatric Associates of the NW, 2701 NW Vaughn St. Suite 360 Portland, OR 97210 and state you are revoking the authorization.

Patient Authorization to Release Information

Signature of Patient or Legally Responsible Person _____

Relationship to Patient _____ **Date** _____

Revised 02/22/2017