pediatric associates OF THE NORTHWEST

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO PEDIATRIC ASSOCIATES

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

I authorize information to be released from

Name/Address: _____

_____

Telephone: _____ **Fax**:_____

Please send general medical records to (for protected information inclusion, see below):

☐ Pediatric Associates of the NW
14795 SW Murray Scholls Dr., Ste. 121
Beaverton, OR 97007
Tel: 503-673-1071
Fax: 503-227-0676

☐ Pediatric Associates of the NW
2701 NW Vaughn St., Ste. 360
Portland, OR 97210
Tel: 503-227-0671
Fax: 503-227-0676

☐ Pediatric Associates of the NW
7150 SW Dartmouth St.
Tigard, OR 97223
Tel: 503-968-3480
Fax: 503-227-4589

Purpose of release (Please check appropriate box)**:**

□ Change of primary care physician/clinic

□ Other (specify) _____

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 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
_____ Alcoholism/Drug Abuse Treatment
_____ Genetic Testing
_____ 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 the authorization is necessary to participate in the research study and receive research related treatment.

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

Patient Authorization to Release Information

Patient Signature _____ **Date**_____

Parent/Guardian Signature if patient is under 18 y.o. _____ **Date** _____