AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: ____ Date of Birth:________________

I hereby authorize: **Pediatric Associates of the Northwest, P.C.**

____ To **provide** protected information to
____ To **obtain** protected information from

____
Name/Organization

____
Address

____
City/State/Zip Code

______________________________ ____________________________
Phone Fax

Date(s) of service requested (if known):____

Description of information to be released (check all that apply):
________ Telephone consultation _______ Initial evaluation ________ Progress notes
________ Testing summary ________ Complete copy of record
________ Written summary of assessment and/or treatment
Other:____

Purpose of the disclosure/use:
________ Continuing care ________ Insurance purposes ________ Legal purposes
________ Personal use ________ Coordination of care ________ Educational planning
Other: ____

To forward the requested information regarding the above named individual to:

Pediatric Associates of the Northwest
2701 NW Vaughn St., Suite 360
Portland, OR 97210
503-227-0671 (telephone)
503-954-1926 (fax)

Pediatric Associates of the Northwest
7150 SW Dartmouth St.
Tigard, OR 97223
503-968-3480 (telephone)
503-477-4775 (fax)

Pediatric Associates of the Northwest
14795 SW Murray Scholls Drive, Suite 121
Beaverton, OR 97007
503-673-1071 (telephone)
503-477-4775 (fax)

I understand that this authorization is voluntary and that I may refuse to sign. I further understand that my ability to obtain treatment or payment or my eligibility for insurance benefits will not be affected if I refuse to sign. I understand that I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed, as indicated in the authorization, may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire six months from the date signed unless I otherwise specify. This authorization will be in effect until______________________________(date or event).

I understand that I may revoke this authorization at any time by notifying the facility from which I am requesting the disclosure. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

______________________________________ ____________________
Signature of patient Date

______________________________________ ____________________
Signature of legal representative Date

______________________________________ ____________________
Printed name of legal representative Relationship to patient