pediatric associates
OF THE NORTHWEST

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name:_____ Date of Birth:_____

I hereby authorize: **Pediatric Associates of the Northwest, P.C.**
2701 NW Vaughn St., Suite 360
Portland, OR 97210

To disclose the above named individual's health information as described below:

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

Description of information to be released (check all that apply):

_____Verbal exchange of information
_____Initial evaluation
_____Termination Summary
_____Complete copy of record
_____Written exchange of information
_____Progress Notes
_____Testing Summary
Other: _____

This information may be disclosed to and used by the following individual or organization:

_____
Name/Organization

_____
Address

_____
City/State/Zip Code

_____ _____
Phone Fax

Purpose of the disclosure/use:
_____Continuing care _____Insurance purposes _____Legal purposes
_____Personal use _____Coordination of care _____Educational planning
Other:_____

AND/OR I hereby authorize:_____
_____

To disclose information regarding the above named individual to:

Beaverton Office
14795 SW Murray Scholls Dr., Ste. 121
Beaverton, OR 97007
Tel: 503-673-1071
Fax: 503-227-0676

Portland Office
2701 NW Vaughn St., Ste. 360
Portland, OR 97210
Tel: 503-227-0671
Fax: 503-227-0676

Tigard office
7150 SW Dartmouth St.
Tigard, OR 97223
Tel: 503-968-3480
Fax: 503-227-4589

portlandpediatric.com

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Description of the information to be released (check all that apply):

_____Medical Record (complete) _____Academic record, transcript, testing
_____Medication List _____Mental health record (complete)
_____Verbal exchange of information _____Written exchange of information
Other:_____.

I understand that this authorization is voluntary and that I may refuse to sign. I further understand my ability to obtain treatment or payment or my eligibility for insurance benefits. I understand that information used or disclosed pursuant to 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 in six months from the date signed unless I otherwise specify. This authorization will be in effect until_____(date of 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

Revocation of authorization

As of _____, I hereby revoke the authorization to disclose health information

to_____.

_____ _____
Signature of patient Date

_____ _____
Signature of legal representative Date

_____ _____
Printed name of legal representative Relationship to patient

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