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.**

____ 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)
503-227-0676 (fax)

Pediatric Associates of the Northwest
7150 SW Dartmouth St.
Tigard, OR 97223
503-968-3480 (telephone)
503-227-4589 (fax)

Pediatric Associates of the Northwest
14795 SW Murray Scholls Drive, Suite 121
Beaverton, OR 97007
503-673-1071 (telephone)
503-227-0676 (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 re-disclosure 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