



Authorization to Discuss Protected Health Information with Parent(s) and or Guardian(s)

Patient Name (please print clearly): _____ Date of Birth: _____

Phone Number: _____ Current Age: _____

Your medical information has different protections under Oregon law. Until you are 18 years of age, your general medical information will be shared with your Parent(s) and/or Guardian(s) unless you have other valid legal documentation. Below, you get to choose what protected health information is shared based on your age.

I DO authorize Pediatric Associates of the NW to discuss the following protected health information with those parent(s) and/or guardian(s) listed below.

Select your choice(s). Only the information checked will be discussed.

- _____ Birth control (any age) _____ Mental health (age \geq 14)
- _____ Drug and/or alcohol use (age \geq 14) _____ Sexual health including sexually transmitted diseases/ HIV/AIDS (any age)

1. Name: _____ Relationship to patient: _____
Phone Number: _____

2. Name: _____ Relationship to patient: _____
Phone Number: _____

This authorization is valid for one year and may be revoked by the patient (verbally or in writing) at any time prior to one year. 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 authorization. Any use or disclosure already made with your permission cannot be undone.

Signature of Patient

Date

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

Portland office
2701 NW Vaughn St., Ste. 360
Portland, OR 97210
Tel: 503-227-0671
Fax: 5003-227-0676
portlandpediatric.com

Tigard office
7150 SW Dartmouth St.
Tigard, OR 97223
Tel: 503-968-3480
Fax: 503-227-0676
portlandpediatric.com