pediatric associates
OF THE NORTHWEST

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Full Name:	Patient DOB:
Patient Address:	Patient Phone:
Please tell us where to send to or obtain records from:	
☐send record to: ☐release record from: Pediatric Associates of the Northwest Name of Provider _____ 2701 NW Vaughn Street, Suite 360 Portland, OR 97210 Ph: 503.227.0671 Fax: 503.227.0676 mrecords@panw.pcc-direct.com	☐send record to: ☐release record from: Name: Address: Phone: Fax: Email:

What records would you like to release?			
☐Office/Clinical Notes	☐ Lab/Pathology Results	☐ Immunizations	☐Imaging/Xray
☐ Radiology Reports	☐Phone / Portal notes	☐ All Records (within the last 6 months)	☐ All Records
If specific dates, please specify: From:_____ To:_____			
☐ Other:			

Certain portions of your medical record are sensitive. If you want any of the following released, please check AND <u>INITIAL</u> the categories below you would like to INCLUDE in the release:		
☐ _____ Substance Abuse, if any	☐ _____ AIDS/HIV/STD's, if any	☐ _____ Mental Health conditions, if any

What is the purpose for this release of information?			
☐Personal Use	☐ Litigation/Legal	☐Insurance	☐ Transfer of Care
How would you like the records sent:			
☐ Secure-direct Email	☐ Fax	☐ Mail (postage fee may apply)	☐ Patient Portal

This authorization is limited to the following time period:_____

This authorization is limited to a worker's compensation claim injuries of:_____

My signature indicates that I authorized the disclosure of the above information and understand the following:

I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been shared.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

Patient Signature (if patient is age 14 years or older):	Date:
Parent/guardian Signature (if patient is under 18 years old:	Date: