pediatric associates OF THE NORTHWEST

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

Patient First Name: _____ **Last Name:** _____

Phone Number: _____ **Date of Birth:** _____ **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 authorize Pediatric Associates of the NW to discuss the following protected health information with those parent(s) and/or guardian(s) listed below. This does not change parent or guardian access to this information on the Patient Portal.

Can we share your information about the topics below with your parent(s)/guardian(s)? CIRCLE your choice for each topic:

Birth control (any age): YES or NO

Drug and/or alcohol use (age ≥ 14): YES or NO

Mental health (age ≥ 14): YES or NO

- If NO, can we contact your parent/guardian about mental health appointment scheduling/reminders? YES or NO

Sexual health including sexually transmitted diseases/ HIV/AIDS (any age): YES or NO

1. First Name: _____ Last Name: _____

   Relationship to patient (CIRCLE ONE): Parent Step-Parent Guardian

2. First Name: _____ Last Name: _____

   Relationship to patient (CIRCLE ONE): Parent Step-Parent Guardian

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**

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