Authorization to Release Health Information (ROI)

PATIENT LABEL HERE

Patient Name: _____ **DOB:** _____/_____/_____ **Phone:** (_____)_____

Address: _____

WHO INFORMATION IS TO BE SHARED WITH

I authorize: Clackamas & Oregon Pediatrics
8645 SE Sunnybrook Blvd., Ste 200, Clackamas OR 97015-6841
Phone: (503) 659-1694 Fax: (503) 659-8984 Email: HIM@orpeds.com

❑ To send records to: Name: _____

❑ To receive records from: Address: _____

❑ To verbally exchange with: City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Send records via: (please check one)

❑ MyHealth ❑ CD (Adobe 8 or higher) ❑ Email _____

❑ Paper ❑ Fax (I understand confidentiality at the receiving end of faxes cannot be guaranteed.)

PURPOSE OF THE RELEASE

❑ Change physician/clinic ❑ Moved ❑ Referral/Consult ❑ Legal

❑ School ❑ Personal use ❑ Other _____

TYPE OF INFORMATION TO BE RELEASED

❑ **General Medical Records** are limited to the most recent [2] years including progress notes, labs, x-rays, and full immunization history. (This is the default if not otherwise indicated.)

❑ Pathology (labs) Only - list date(s) _____ ❑ Radiology (x-rays) Only - list date(s) _____

❑ Immunizations Only ❑ Medications Only ❑ Other: _____

PROTECTED OR SENSITIVE INFORMATION

I understand specific information cannot be released without authorization as required by State/Federal Law.
By INITIALING below, I authorize the release of the following protected/sensitive information:

_____ (initial) AIDS/HIV Test Results _____ (initial) ADD/ADHD/Mental Health Diagnosis/Treatment

_____ (initial) Genetic Testing _____ (initial) Alcoholism/Drug Abuse Treatment

AUTHORIZATION

I have read & understand the following: **(1)** The information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. Federal/State law may restrict redisclosure of Protected or Sensitive Information; **(2)** You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure; **(3)** You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has acted in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage; **(4)** To revoke this authorization, please send a written statement to Clackamas & Oregon Pediatrics, Central Records Dept. and state that you are revoking this authorization. Unless revoked earlier, this consent will expire 6 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

X_____ _____ _____/_____/_____

Signature of Parent / Legal Guardian **Relationship to Patient** **Date Signed**