AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

In order to be valid, this form must be completed in full including signature(s) and date(s) wherever applicable.

Patient's Full Name____ Date of Birth ____/____/_____

Address____ City____________________ State_______ Zip___________

Home Phone (_______) __________-_______________ Work Phone (______) _________-______________

I authorize (select one clinic): **Central Fax - Clackamas & Oregon Pediatrics: <u>(503) 659-8984</u> Attn: Medical Records**

❒ Clackamas Pediatric Clinic	❒ Oregon Pediatrics – NE Portland	❒ Oregon Pediatrics – Happy Valley	❒ Oregon Pediatrics – Meridian Park
9290 SE Sunnybrook Blvd., #200	5050 NE Hoyt St., #B55	16144 SE Happy Valley Tn Ctr Dr #210	19260 SW 65th Ave., #275
Clackamas, OR 97015	Portland, OR 97213	Happy Valley, OR 97086	Tualatin, OR 97062
(503) 659-1694	(503) 233-5393	(503) 427-2637	(503) 691-2519

<u>Select One</u> <u>and complete right ⇨</u>: Clinic/Provider/Other Name:____

❒ To forward records to: Address: ____

❒ To receive records from: City: ______________________________ State: __________ Zip: ________________

❒ To verbally exchange with: Phone: (______)____________________ Fax: (______)________________________

Purpose of release (check only one): ❒Change healthcare provider ❒ Consultation ❒ Legal
❒ Other: ____

By **initialing** in the spaces below, I specifically authorize the release of that specific medical information:

____ Clinician office chart notes ____ Immunization history ____ Hospital reports
____ Diagnostic Imaging reports (X-rays…) ____ Laboratory reports ____ Other___________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

______ HIV/AIDS ______ Mental Health/ADD/ADHD diagnosis, treatment or referral

______ Genetic testing information ______ Drug/Alcohol diagnosis, treatment or referral information

The medical information authorized above (check only one) ❒ **MAY** or ❒ **MAY NOT** be faxed. I understand there is a risk in faxing records and confidentiality cannot be guaranteed.

<u>My signature below indicates that I understand and agree to the following:</u>

- The information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.
- The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.
- I may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means I 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.
- This is not a blanket authorization for release of information. It is intended for one-time use only. I must re-execute it should additional requests for information occur. This authorization may be revoked at any time unless prior action has been taken as a result of this form. Unless revoked earlier, this consent will expire in 180 days from the date of signing.
- That proof of guardianship or a court order may be required if signing for a person under 18 years of age.

____ ___________________________ ____________
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN RELATION TO PATIENT DATE

____
PRINTED NAME OF PATIENT/PARENT/LEGAL GUARDIAN