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___________

Primary Phone (_______) __________-_______________ Secondary Phone (______) _________-______________

I authorize (select one clinic):
❒ Clackamas Pediatric Clinic
❒ Oregon Pediatrics – NE Portland
❒ Oregon Pediatrics – Happy Valley
❒ Oregon Pediatrics – Meridian Park

Address: Clackamas & Oregon Pediatrics, Central Records Dept., 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015-6777

Phone: (503) 659-1694 Fax: (503) 659-8984

Select One and complete right ⇨:
❒ To forward records to:
❒ To receive records from:
❒ To verbally exchange with:

Clinic/Provider/Other Name:_______________________________________
Address: ____
City: ______________________ State: __________ Zip: ________________
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.

My signature below indicates that I understand and agree to the following:

- 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 or Legal Representative

_________________________ RELATION to Patient

__________ DATE

_____________________________________ PRINTED NAME of Patient or Legal Representative

V01-2014