Request for Release of Medical Information

I hereby authorize:

Hillsboro Pediatric Clinic LLC
445 East Main Street
Hillsboro, OR 97123-4084
Phone #: 503-640-2757
Fax #: 503-640-9753

Patient's Name: _____

Patient's Date of Birth: _____

To Provide Medical Information to:

Name of Individual/Facility/Agency: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Fax #: _____

Permission to fax and/or send electronically _____YES _____ NO

All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be assured.

Reason for Request (Must be Complete):

If the request is for Attorney/Legal purposes we will respond to an attorney's request or valid subpoena.

❑ Transferring Care ❑ Specialty or other Health Care Provider ❑ School Entry ❑ Personal

❑ Other: _____

Based on your selection we will provide minimally necessary documents as required by law. If there is special information that you require please indicate below.

Data Requested (please ***initial*** appropriate choices):

_____ X-Ray Results

_____ Last Physical Exam

_____ Only shot record

_____ Operative/Pathology Reports (specify Condition) _____

_____ Medication Summary

_____ Consultations

_____ Other Health Information

Dates: _____ to _____

By Initialing and **Signing,** I specifically authorize the release of the following protected information:

_____ HIV test and test results and related information including high risk behavior documentation

_____ Drug/Alcohol diagnosis, treatment or referral information

_____ Mental Health treatment information

_____ Genetic Information

_____ Attention Deficit Disorders

_____ Specify _____

_____ _____ _____ _____

Parent/Legal Guardian Signature **Date** **Patient Signature** **Date**

I authorize disclosure of my medical record for the purpose stated above. I further understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for one (1) year from the date it is signed, or expires on: _____/_____/_____

Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect the information.

Signature of Requestor: _____ **Date:** _____

Requested by: *Choose One (1)* ❑ Patient ❑ Parent ❑ Legal Guardian ❑ Power of Attorney

Print Name of Requestor: _____

STAFF ONLY

I have verified: ❑ Form is complete ❑ Identification of Requestor ❑ Relationship if not patient

Processed by:

Name: _____ Position: _____ Date: _____