Outgoing Request for Release of Medical Information

Return Requested Health Information to:

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: _____

This information is being requested from:

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):

❑ Transferring Care ❑ Continuity of Care

❑ Other: _____

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

_____ Portions of Medical Record necessary for ongoing care, including shot records
_____ History & Physical
_____ Operative/Pathology Reports
_____ Progress Notes
_____ Only shot record
_____ X-Ray Reports
_____ Medication Summary
_____ Consultations
_____ Most Recent 2 years
_____ 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 if not Patient: _____

STAFF ONLY

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

Processed by:

Name: _____ Position: _____ Date: _____