Authorization to Use and/or Disclose Patient Health Information

Hillsboro Pediatric Clinic LLC

Return Health Information to: Hillsboro Pediatric Clinic LLC | 445 E Main St.| Hillsboro, OR | 97123
P 503-640-2757 | **F** 503-640-9753 | **E** HPCMedicalRecords@hillsboropediatrics.com
****ONLY EMAIL USING SECURE EMAIL**

1. I authorize the following providers to use and/or disclose patient health information regarding my child:

Last Name:	First:	Middle:	Birth Date:
Other Names Used by Patient:			

Street Address:	Apt. #:	City/Town:	State:	Zip Code:

2. ☐ Send records to ☐ Request records from ☐ Mutually Exchange records with

Name: _____ Phone: _____

Address: _____ Fax: _____

_____ Email: _____

Permission to fax and/or send electronically YES____ NO_____. All faxed and secure emailed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be assured.

3. Purpose of this request (check one):

☐ **Transferring Care** ☐ **Continuing Care** ☐ **School Entry** ☐ **Personal** ☐ **Other:** _____

4. Patient Health Information to be Released:

☐ Minimal necessary for ongoing care including:
- Growth Charts
- Vaccine Record
- Most Recent Well Child Check (Physical)
- Medication Summary
- Last 2yrs of Specialty Consults (if any)

☐ Vaccine Record ☐ Most Recent Well Child Check

☐ Other: _____

Specially Protected Records

By Initialing below, I specifically authorize the release of the following protected information:

_____ HIV/AIDS Testing

_____ Mental Health Records

_____ Genetic Testing

_____ Drug/Alcohol diagnosis, treatment or referral information

5. Authorization Limits

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.

6. Legal Parent/Patient Signed Authorization

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: _____ Date: _____