

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

East Portland Pediatric Clinic, P.C.

Physicians

10,000 S.E. Main St. Suite 30

Portland, OR 97216

Phone: 503-255-3544 Fax: 503-251-6827

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

I authorize East Portland Pediatric Clinic to exchange medical information as specified below with:

Name or facility: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

- Requesting records from above facility to be sent to EPPC
- EPPC to mail to the above address (no charge if mailed to new physician)
- Patient to Pick up records at EPPC

This information will be used on my behalf for the following purpose(s).

\_\_\_\_\_ New Primary Care Physician

\_\_\_\_\_ Other \_\_\_\_\_

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

\_\_\_\_\_ All non-confidential progress notes, lab reports, radiology reports from the last 3 years for the continuity of care.

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ X-Ray Reports

\_\_\_\_\_ Other: \_\_\_\_\_

The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.

This authorization may be revoked at any time by notifying E.P.P.C. in writing. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. I understand that any revocation will not have any effect on any information already used or disclosed before E.P.P.C. received the revocation.

\_\_\_\_\_  
(Signature of Patient or Person Authorized By Law)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Relationship to Patient)