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
Secure email for medical records: businessoffice@eastportlandpeds.com

Patient Name: _____ D.O.B.:_____

Address: _____
Street, City, State, Zip
Primary Phone #: _____Secondary phone#_____

I Authorize Information Released FROM: (please print)	Please SEND MY RECORD TO: (please print)
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone# fax#	Phone# fax#

Purpose of Release

☐ Moving ☐ Legal purposes ☐ Personal use($30 fee applies)
☐ Insurance change ☐ Exchange of information ☐ Dissatisfied with Clinic
☐ Other:_____

Type of Information To Be Released

☐ **Transfer of Care**-information that physicians find most useful:
Most Recent Well Child Check (Physical), Last 2yrs of Specialist Consults (if any), Problem list, vaccine record, allergies, medication summary, lab/xray summary, visit list, vitals & referrals.

☐ **Other:**(please specify)_____

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

_____ Mental Health/Treatment
_____ Drug Abuse Diagnosis/Treatment
_____ Alcoholism Diagnosis/Treatment
_____AIDS/HIV Test Results
_____Sexually Transmitted Diseases

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. Records will be sent within 30 days of receipt of completed authorization.

_____ _____
(Signature of Patient or Person Authorized By Law) (Date)

_____ _____
(Printed Name) (Relationship to Patient)