



Integrative Pediatrics, LLC

Safe passage in a changing world.

Ph. 503.643.2100

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Authorization to Release Medical Records

Patient Name DOB

Patient Name DOB

Patient Name DOB

Patient Name DOB

Purpose of Release: _____

I Authorize: _____ to release information to: **Integrative Pediatrics, LLC**

Address

City, State, Zip

11790 SW Barnes Rd. Bldg. A, Suite 140

Portland, OR 97225

Please Initial the spaces below the records you would like released.

_____ Entire Medical Record _____ Immunizations Only _____ Lab Reports

_____ Pathology Reports _____ Billing Statements

_____ Specific Record (please list)

Separate and Signed authorization form is required for the following:

- * HIV/ AIDS related records *Drug/Testing diagnosis, treatment and referral information*
- *Mental health information * Genetic Testing*

Recipient other than physicians agrees to pay all charges associated with this request.

Signature Relation to patient Date