



Integrative Pediatrics

Safe passage in a changing world.

Authorization to Release Medical Records

Send Records / Record Requests / Revocation Requests to **Integrative Pediatrics Medical Records**
 11790 SW Barnes Road • Portland, OR 97225 • P 503-643-2100 • F 503-643-7300 • drpaul.md

Patient Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Address: _____
 Street City State Zip Code

I Authorize My Health Information to Be:

- Sent to: Verbally exchanged with:
 Requested from: **I do not authorize release of records. Cell phone (____)-____-____**

Parent/Guardian #1 Name: _____

Parent/Guardian #1 Name: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Email: _____

- My health information: **MAY** or **MAY NOT** be faxed.
 MAY or **MAY NOT** be securely emailed.

Purpose of Release:

- Permanently Changing Physician/Clinic
 Personal Use**
 Legal
 Parent/Guardian Use: _____
 Consult/Sharing With Other Provider

**There is a charge for any personal request for medical records. Your request will be processed within 30 days.

Indicate Type of Information to Be Released Below:

General Medical Records

Excluding protected records. Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports, and immunizations.

–OR–

Specific Information Only:

- Medical Records for Specific Date(s): _____
 Medications
 Lab, Pathology, EKG, etc.
 X-ray, MRI, CT, etc.
 Immunizations Only
 Problem List
 Treatment Plans/Progress Notes



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Protected or Sensitive Information:

By **INITIALING**:

I authorize the release of the following protected or sensitive information. **Patients 14+ must provide initial.** I understand that certain information **cannot** be released without specific authorization as required by State/Federal law.

_____	(initial) DRUG & ALCOHOL DIAGNOSIS/TREATMENT
_____	(initial) ADD/MENTAL HEALTH TREATMENT
_____	(initial) AIDS/HIV TEST RESULTS (incl. related high-risk behavior)
_____	(initial) GENETIC TESTING
_____	(initial) FAMILY PLANNING OPTIONS (birth control, tests)

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information. You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan. You have the right to revoke this authorization at any time by providing a written request for revocation to Integrative Pediatrics. If you revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. **Unless otherwise revoked, this authorization will expire 2 years from the date signed or will expire on the following date, event, or condition: _____.**

X _____	_____	X ____/____/____
Signature of Parent or Legally Responsible Person	Print Name Relationship	Date
X _____	_____	X ____/____/____
Signature of Patient 14+ years – REQUIRED	Print Name	Date

Records Fees If Transferring to Someone Other Than Another Doctor's Office

- \$20.00 - For First 25 Pages
- \$0.25 - For Each Page Over 25
- \$5.00 - Rush Charge If Done Within 7 Days
- Postage - If Being Mailed

INTERNAL USE ONLY

I have verified: Form is complete Identity of requester

Relationship (if not patient) Payment received: ____/____/____

Employee Name: _____ Date: ____/____/____