Integrative Pediatrics

Safe passage in a changing world.

Authorization to Release Medical Records

All sections of this form ***MUST*** be completed or the authorization will not be valid

Send Records / Record Requests / Revocation Requests to Integrative Pediatrics Medical Records
11790 SW Barnes Road #140 • 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 (___)-________-_________**

Name #1: ____

Name #2: ____

Address: ____

City/State/Zip: ____

Phone: (_______) ______________________ Fax: (_______) ______________________ (Fax number must be included)

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, Titers (MMR,varicella,etc)

❑ X-ray, MRI, CT, etc.

❑ Immunizations Only

❑ Problem List

❑ Treatment Plans/Progress Notes

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

<u>Records Fees - If Transferring to someone other than another doctor's office</u>

- $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: _____/_____/_____