Integrative Pediatrics
Safe passage in a changing world.

# Patients Age 14+ Release of Information to Individual

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

**Integrative Pediatrics**
11790 SW Barnes Road Bldg. A, Ste. 140, Portland, OR 97225 • P: 503-643-2100 • F: 503-643-7300

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Phone: (_____)_____ Is it okay to leave a confidential voicemail at this number? Y / N

Patient Email: _____

## I authorize release to, and discussion with, the individual(s) listed below

Name: _____ Relationship to patient _____

Phone: (_____)_____ Email: _____

Name: _____ Relationship to patient _____

Phone: (_____)_____ Email: _____

❑ I do NOT authorize a medical information release to/from my parent/guardian

## Indicate Type of Information to Be Released Below:

❑ All medical information

-OR only specific information ONLY (indicated below)-

❑ Medications ❑ Lab, Pathology, EKG, Titers (MMR, varicella, etc) ❑ Imaging results
❑ Vaccines ❑ Treatment Plans/Progress Notes ❑ Problems list

## Protected and Sensitive Information

I understand that, UNLESS the spaces below are initialed, I agree to the following information, if it is indicated in the medical record, and which is protected by state or federal law, to be disclosed to Integrative Pediatrics:

**By *INITIALING*, I *DO NOT* agree for the following protected information to be released:**

_____ DRUG & ALCOHOL DIAGNOSIS/TREATMENT

_____ ADD/MENTAL HEALTH TREATMENT

_____ AIDS/HIV TESTING (incl. related high-risk behavior)

_____ GENETIC TESTING

_____ FAMILY PLANNING OPTIONS (birth control, tests, etc.)

Integrative Pediatrics
Safe passage in a changing world.

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. I am under no obligation to sign this form, and I 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. I have the right to revoke this authorization at any time by providing a written request for revocation to Integrative Pediatrics. If I 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_____ _____ _____/_____/_____

Signature of Patient 14+ years – REQUIRED  Print Name  Date