Integrative Pediatrics

Safe passage in a changing world.

Authorization to Release Medical Records to Integrative Pediatrics

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

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

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

Phone: (_____)_____ Email: _____

_____

Street Address City State Zip Code

I authorize release from the provider/facility listed below:

Name: _____

Address: _____

City/State/Zip: _____

Phone: (_____) _____ Fax: (_____) _____ (Fax number required)

Email: _____ ❑ I authorize verbal discussion of my medical info

Purpose of Release:

❑ Transfer of Care to Integrative Pediatrics ❑ Continuity of Care ❑ Other:_____

Indicate Type of Information to Be Released Below:

❑ **All Medical Records** (2 years of medical info)
❑ All Medical Records for Specific Date(s) listed:
_____

–OR–

Specific Information Only (indicate dates up to 2 years of history)**:** _____

❑ Medications
❑ Lab, Pathology, EKG, Titers (MMR, varicella, etc.)
❑ X-ray, MRI, CT, etc.
❑ Vaccines Only
❑ Problem List
❑ Treatment Plans/Progress Notes

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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 diagnosis/treatment

_____ AIDS/HIV testing & high-risk behavior

_____ Genetic testing

_____ Family planning (birth control, tests, etc.)

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 Parent or Legally Responsible Person | Print Name | Relationship | Date

X_____ _____ _____/_____/_____

Signature of Patient 14+ years – REQUIRED | Print Name | Date