## NW PEDIATRICS

## INTEGRATIVE MEDICINE

## MEDICAL RECORDS RELEASE TO NWPIM

Authorization to Use/Disclose Protected Health Information

I authorize: NW Pediatrics Integrative Medicine, LLC to use and disclose a copy of the specific health information described below:

The purpose of this release is for:  Personal Records  Follow-up care  Diagnostic evaluation  Legal*  Reimbursement  Other  Bv marking the boxes below, I specifically authorize the release of the following:  Billing Statements  Entire Medical  Other  Breath Notes  Lab Reports  Diagnostic Imaging Reports  Billing Statements  Entire Medical  Other  Breath Notes  Advances for copying your records.  Please SEND my records FROM:  Name: NW Pediatrics Integrative Medicine, LLC  Name:  Address: 11790 SW Barnes Rd Bldg A Ste 140  Address:  City/ST/Zip: Portland, OR 97225  City/ST/Zip:  Phone# 503.643.2100  Fax# 503.643.7300  Phone# Fax#  If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place  in  HIV/AIDS information  Mental health information	Patient's Name				
Legal*   Reimbursement   Other	Pirst Name  Date of Birth: / / /				
By marking the boxes below, I specifically authorize the release of the following:    Chart Notes	The purpose of this release	is for:   Personal Records	☐ Follow-u	up care Diagnostic evaluation	
Chart Notes   Lab Reports   Diagnostic Imaging Reports   Billing Statements   Entire Medical   Other   *There may be a charge for copying your records.    Tauthorize information TO:   Please SEND my records FROM:   Name: NW Pediatrics Integrative Medicine, LLC   Name:	☐ Legal* ☐ Reiml	oursement   Other			
□ Other**There may be a charge for copying your records.  I authorize information TO: Please SEND my records FROM:  Name: NW Pediatrics Integrative Medicine, LLC Name:  Address: 11790 SW Barnes Rd Bildg A Ste 140 Address:  City/ST/Zip: Portland, OR 97225 City/ST/Zip:  Phone# 503.643.2100 Fax# 503.643.7300 Phone# Fax#  If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my init the applicable space next to the type of information.  — HIV/AIDS information — Genetic testing information — Genetic testing information — Alcohol/chemical dependency diagnosis, treatment, or referral information Sexually transmitted disease information  I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependingnosis, treatment or referral information and specifically requires my authorization prior to disclosure.  PATIENT INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely our ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means not receive health care services is if the health care services represent research related treatment and the authorization in writing at any till you revoke your authorization, the information described above may no longer be used or disclosed for the purposes describe written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorizatio please send a written request to NW Pediatrics Integrative Medicine, LLC 11790 SW Barnes Rd Bldg A Ste 140 Portland, Of SignATURE: I have read and understand this authorization. Unless revoked, this authori	By marking the boxes be	low, I specifically authorize	the release of the fo	ollowing:	
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year from the date of this signed form.	protected under federal law. diagnosis, treatment or reference of the partient in the receive health not receive health care service participate in the research studyou revoke your authorization written authorization. Any use	Mental health information Genetic testing information Alcohol/chemical depende Sexually transmitted disease tion used or disclosed pursuant to However, I also understand that fall information and specifically re N: You do not need to sign this care services or reimbursement to test is if the health care services re day and receive research related to n, the information described abore se or disclosure already made with	ency diagnosis, treatments of this authorization may federal law restricts receptures my authorization authorization. Refusal for services. The only compresent research related treatment. You may revive may no longer be useful to the service of the services of the servi	by be subject to redisclosure and no longer be disclosure of alcohol and chemical dependency on prior to disclosure.  Ito sign the authorization will not adversely affect circumstance when refusal to sign means you will ad treatment and the authorization is necessary to woke this authorization in writing at any time. If sed or disclosed for the purposes described in this not be undone. To revoke this authorization,	
By: Date: (Patient or Personal Representative)	year from the date of the	nis signed form.		·	
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Description of Personal Representative's Authority:					