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:

Patient's Name_____
First Name M.I. Last Name

Date of Birth: ____/____/____ **Contact #:**_____

The purpose of this release is for: ☐ Personal Records ☐ Follow-up care ☐ Diagnostic evaluation

☐ Legal* ☐ Reimbursement ☐ Other_____

By marking the boxes below, I specifically authorize the release of the following:

☐ Chart Notes ☐ Lab Reports ☐ Diagnostic Imaging Reports ☐ Billing Statements ☐ Entire Medical Record

☐ 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 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 the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place **my initials** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health 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 be protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependency diagnosis, 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 affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written request to NW Pediatrics Integrative Medicine, LLC 11790 SW Barnes Rd Bldg A Ste 140 Portland, OR 97006.

SIGNATURE: I have read and understand this authorization. Unless revoked, this authorization expires one year from the date of this signed form.

By:_____ Date:_____
(Patient or Personal Representative)

Description of Personal Representative's Authority:_____