



16463 Boones Ferry Rd Suite 400
Lake Oswego, OR 97035
Tel: 503-635-3743 Fax: 503-635-1508

Authorization to Release Medical Records FROM Olson Pediatric Clinic

Patient Name _____ DOB _____ Phone _____

Current Address _____ City _____ State _____ Zip _____

I authorize information to be sent to:

Physician/Clinic/Third Party Name

Address

City, State, Zip

Phone # _____ Fax # - see consent below*

Purpose of Release: check one

- Changing Primary Care Physicians/Clinic
- Referral/Consultation
- Insurance
- Legal
- Personal use- not a transfer of care

I do/do not

* specifically consent to the transmission of medical records via facsimile (Fax) machine with the understanding that the confidentiality at the receiving end cannot always be guaranteed

Please specify below the type of information to be released:

_____ **GENERAL MEDICAL RECORDS**-excluding protected records

Copies of medical records will be limited to two (2) years of information including progress notes, labs, x-ray reports and immunizations.

_____ **SPECIFIC INFORMATION ONLY:** from _____ to _____

- History & Physical
- Medications
- Lab, Pathology, EKG
- X-ray Reports
- Films
- Operative Report
- Accident or Injury
- Immunizations ONLY
- Other

Protected or sensitive information: Some types of information require a specific authorization to be released because of federal or state laws. They are identified below. By initialing and signing, I specifically authorize the release of the following confidential information.

(Each individual item must be initialed by parent or patient if over 14 years old)

- _____ HIV test/results including related high risk behavior
- _____ Drug/Alcohol diagnosis, treatment, or referral information
- _____ Mental Health treatment information
- _____ Genetic Testing

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be disclosed if the recipient is not required by law to protect the privacy of the information. You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received before release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing. You are under no obligation to sign this form; 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 in connection with eligibility or enrollment in a health plan.

Signature of patient/parent or guardian (**patients 14 over must sign**) relationship to patient date
Name printed _____ (This authorization expires 1 year from date signed)