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

Authorization to Release Medical Records TO Olson Pediatric Clinic

Patient Name _____ DOB _____ Phone _____

Current Address _____ _____ City _____State ___ Zip_____

I authorize information to be sent FROM:

_____
Physician/Clinic/Third Party Name

_____
Address

_____
City, State, Zip

_____
Phone # Fax # - see consent below*

Released to:

Olson Pediatric Clinic
16463 Boones Ferry Road, Suite 400
Lake Oswego, OR 97035

Purpose of Release: check one

- Changing Primary Care Physicians/Clinic
- Referral/Consultation
- Other _____

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 must initial 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)