WESTSIDE PEDIATRIC CLINIC

9555 SW Barnes Rd #270 Portland, OR 97225
Phone: (503) 297-1025 Fax: (503) 297-1043

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or by person authorized by law to give authorization

Records can be securely emailed to: medicalrecords@westsidepediatrics.com

Patient:_____ DOB:_____

Patient:_____ DOB:_____

Patient:_____ DOB:_____

I authorize_____ to release information to_____
(name of provider) (name of provider)

_____ _____
(address of provider) (address of provider)

_____ _____
(city, state, zip) (city, state, zip)

Purpose of disclosure:_____

By initialing the spaces below, I specifically authorized the release of the following medical records, if such records exist:

____Entire Medical Record ____Diagnostic Imaging ____Lab/Pathology reports

____Immunization record only ____Clinician office chart notes

The recipients understands that this record may be voluminous and agrees to pay all reasonable charges associated with providing this record

Please note there is a $30.00 charge for any personal requests

Protected or Sensitive Information:

I understand that certain information cannot be release without specific authorization as required by state/federal law. By INITIALIING, I authorize the release of the following protected or sensitive information.

___ HIV/AIDS TEST RESULTS ___DRUG DIAGNOSIS/TREATMENT

___GENETIC TESTING ___ADD/MENTAL HEALTH TREATMENT

SIGNATURE:_____ **Date:**_____

This authorization may be revoked at any time; the only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of the signing or shall remain in effect for the period reasonably needed to complete the request.

GERALDINE KEMPLER, MD
FAYE JOHNSON, MD
NITZA QUILES, MD
MELISSA GIUSTINI, MD

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