AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
In order to be valid, this form must be completed in full including signature(s) and date(s) wherever applicable.

Patient's Full Name_____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

I authorize: **Woodburn Pediatric Clinic** **phone: 503-981-5348**
2050 Progress Way **fax: 503-981-0423**
Woodburn, OR 97071

Select One and complete:
_____To forward records to:
_____To receive records from:
_____To verbally exchange with:
_____ Electronic Copy of records:

Clinic/Provider/Other Name: _____
Address: _____
City: _____State _____Zip: _____
Phone: (____) _____ FAX: (____) _____

Purpose of release (check only one): _____ Change healthcare provider _____ Consultation _____Legal

Other: _____

By **initialing** in the spaces below, I specifically authorize the release of that specific medical information:

____Clinician office chart notes ____Immunizations history ____Hospital reports
____Diagnostic Imaging reports (x-rays.) ____Laboratory reports ____Other_____
____Specific timeframe: _____ ____Entire chart

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 _____Mental Health/ADD/ADHD diagnosis, treatment or referral
_____Genetic testing information _____Drug/Alcohol diagnosis, treatment or referral information

The medical information authorized above (circle only one) **MAY or MAY NOT** be faxed/emailed. I understand the risk of faxing/emailing records and confidentiality cannot be guaranteed.

My signature below indicates that I understand and agree to the following:

- The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.
- The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.
- I may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- This is not a blanket authorization for release of information. It is intended for one-time use only. I must re-execute it should additional requests for information occur. This authorization may be revokes at any time unless prior action has been taken as a result of this form. Unless revoked earlier, this consent will expire in 180 days from the date of signing. That proof of guardianship or a court order may be required if signing for a person under 18 years of age.

_____ _____ _____ _____
Signature of Patient/Parent/Legal Guardian Printed Name RELATION TO PATIENT DATE

IF MORE THAN 25 PAGES, DO NOT FAX