Eugene Pediatric

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize information to be released

Please send my records

FROM: Name of Facility	то:	Eugene Pediatric Associates, LLC
PO Box/Street Address		995 Willagillespie Rd
City, State, Zip		Eugene, OR 97401
Phone Number		Ph: 541-484-5437
Fax Number		Fax: 541-484-0155
Purpose of this release: Medical Care Transfer of Care Relocating Other	🗆 Legal 🛛	Billing Request for personal
Information to be Released: All Medical Records (Records will be to the last 2 year of informationunless otherwise indicated)		Must be initialed to be included in other documents* HIV/AIDS information Mental Health information
Physician Notes Z-Ray Reports	_	Genetic Testing information Drug and Alcohol diagnosis, treatment, or referral
Lab and/or Pathology Reports Other		formation, which requires under federal law a description how much and what kind of information is to be disclosed.

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

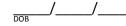
We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;

- You may inspect a copy of the protected health information to be used or disclosed;
- ➢ You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Unless revoked earlier, this Authorization shall remain in effect for 12 months or until age 13, whichever comes first,

Patient Name (Printed)



Phone Number

Name of patient or legally responsible person (Printed)

Relationship to patient

Todays' Date

Signature of patient or legally responsible person