Eugene Pediatric
ASSOCIATES

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize information to be released

FROM:_____
Name of Facility

_____
PO Box/Street Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

Please send my records

TO: Eugene Pediatric Associates, LLC

995 Willagillespie Rd

Eugene, OR 97401

Ph: 541-484-5437

Fax: 541-484-0155

Purpose of this release:

❑Medical Care ❑ Transfer of Care ❑Relocating ❑Legal ❑Billing ❑Request for personal
❑Other_____

Information to be Released:

_____ All Medical Records (Records will be to the last 2 years of informationunless otherwise indicated)
_____ Physician Notes
_____ X-Ray Reports
_____ Lab and/or Pathology Reports
_____ Other_____

Must be initialed to be included in other documents

_____ HIV/AIDS information
_____ Mental Health information
_____ Genetic Testing information
_____ Drug and Alcohol diagnosis, treatment, or referral information, which requires under federal law a description of 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) DOB Phone Number

_____ _____ _____
Signature of patient or legally responsible person Name of patient or legally responsible person (Printed) Relationship to patient

_____
Todays' Date