

THE CHILDREN'S CLINIC, P.C.

www.childrens-clinic.com

Authorization for The Children's Clinic to Receive Medical Information

RELEASE FROM:

Name of person receiving information:

Title (Patient, Physician, Attorney, etc...):

Facility name:

Street address:

City / State / ZIP:

Phone:

Fax:

E-Mail Address:

SEND TO: (Enter physician's name and check appropriate clinic location.)

Physician name:

The Children's Clinic PETERKORT
Peterkort Centre I
9555 SW Barnes Road
Suite 301
Portland, OR 97225
(503) 297-3371 FAX: 297-7975

The Children's Clinic TUALATIN
Meridian Park Medical Plaza 2
19260 SW 65th Avenue
Suite 340
Tualatin, OR 97062
(503) 691-9777 FAX: 692-6736

Patient's last name_____
First name_____
M.I._____
Birth date_____
Patient's last name_____
First name_____
M.I._____
Birth date_____
Patient's last name_____
First name_____
M.I._____
Birth date_____
Patient's last name_____
First name_____
M.I._____
Birth date**Purpose of release:** _____ All pertinent medical records X-Ray Films (specify): _____ Specific Information as described: _____

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.

____ Drug/Alcohol diagnosis, treatment, or referral information

____ Genetic testing _____ HIV/AIDS records _____ Mental health records

This authorization may be revoked at any time except to the extent that the release of information has already occurred. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of person authorizing release of Information: _____**Relationship to patient:** _____ **Date:** _____