Authorization to Release and Receive Protected Health Information

Patient's Last Name:	Patient's First Name:	Patient's Middle Name:
Patient's Date of Birth:		

I authorize: (Person/Entity Releasing your PHI)			To Disclose To: (Person/Entity Receiving your PHI)		
Name: Heartfelt Pediatrics			Name:		
Address: 1001 SW DISK DR., Suite 250			Address:		
City: BEND	State: OR	Zip: 97702	City:	State:	Zip:

Reason for Records Release:

☐ Continuity of Care ☐ Insurance ☐ Legal ☐ FMLA/Disability ☐ Return to Work ☐ Other: _____

Please INITIAL all types of information to be released:

____ All medical records (last 2 years)*	____ Provider notes
____ Immunization records	____ Hospital records/consultations
____ Lab/pathology reports	____ Imaging reports
	____ Other: _____

*All medical records includes provider notes, lab/pathology reports, hospital records/consultations and immunization records for the last 2 years unless otherwise specified

If the information to be used/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 used or disclosed if I **place my initials** in the applicable space next to each type of information:

____ Drug/alcohol diagnosis, treatment or referral information	____ HIV/AIDS information
____ Mental health information- including provider notes	____ Genetic testing information

Records Release Format and Delivery Method:

☐ Paper	☐ Mail to address above
☐ Electronic	☐ Fax: (Please provide number) _____

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. I specifically give authorization to fax or electronically provide my medical information. I understand that risk is involved in electronically transmitting records and confidentiality at the receiving end cannot always be guaranteed. All disclosed information will contain a confidentiality statement and instructions for returning misdirected information. _____(INITIALS)

Your healthcare and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that, you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to **Heartfelt Pediatrics LLC at 1001 SW Disk Dr., Ste 250, Bend, OR 97702** that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. Records will be released within 30 days of receipt of this authorization.

This Authorization will expire on the earlier of _____(date), 365 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Parent/Legal Guardian's Printed Name: _____

Parent/Legal Guardian's Signature: _____ Today's Date: _____