Siskiyou Pediatric Clinic LLP

700 SW Ramsey Ave. Suite 204
Grants Pass, OR 97527
Phone (541) 955-5683
Fax (541) 955-0983

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
(Release of Information)

PATIENT NAME: **DATE OF BIRTH:**

I hereby authorize: **SISKIYOU PEDIATRIC CLINIC, LLP**
700 SW RAMSEY AVE., STE. 204
GRANTS PASS, OR 97527

☐ **To release records to:** ☐ **To request records from: (check one)**

Name:

Address:

Phone #: **Fax #:**

For the purpose(s) of: ☐ **Transferring Care** ☐ **Continuity of Care** ☐ **Other:** _____

By initialing the spaces below, I specifically authorize the release of the following medical records, of such records exist. Please initial for release of records (do not check spaces).

____Entire Medical Records
____All Pertinent Medical Records (for last 2 years)
____Immunization Records
____Laboratory Reports/Pathology Reports
____Physical Therapy records
____Diagnostic Imaging Reports
____Other (specify): _____

____This authorization is limited to the following treatment: _____
____This Authorization is limited to the following time-period: _____
____This Authorization is limited to Worker's Comp claims for injuries of: _____

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 information
____ Mental health information
____ Genetic testing information
____ Drug/Alcohol diagnosis, treatment, or referral information

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. This Authorization shall remain in effect for one (1) year from the date signed, unless terminated sooner in writing.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you 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.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to our Medical Records Department at:
Siskiyou Pediatric Clinic, 700 SW Ramsey Ave., Ste 204, Grants Pass, OR 97527 and state that you are revoking this authorization.

_____ _____ _____
Signature of patient or legally responsible person | Relationship to patient | Date

_____ _____
Printed Name of responsible person* | Phone # of responsible person

*In the event a legal representative other than parents of a minor child signs this Authorization, documentation of legal authority must be attached (e.g., Healthcare Power of Attorney or Court appointed Health Care Representative.) Resource (foster) parents are not permitted to sign this Authorization. It must be signed by a DHS Representative.