



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:			Name: Heartfelt Pediatrics		
Address:			Address: 1001 SW DISK DR., Suite 250		
City:	State:	Zip:	City: BEND	State: OR	Zip: 97702

Reason for Records Release:	
<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> FMLA/Disability <input type="checkbox"/> Return to Work <input type="checkbox"/> Other: _____	
Please INITIAL all types of information to be released:	
<input type="checkbox"/> All medical records (last 2 years)* <input type="checkbox"/> Immunization records <input type="checkbox"/> Lab/pathology reports	<input type="checkbox"/> Provider notes <input type="checkbox"/> Hospital records/consultations <input type="checkbox"/> Imaging reports <input type="checkbox"/> Other: _____
<small>*All medical records includes provider notes, lab/pathology reports, hospital records/consultations and immunization records for the last 2 years unless otherwise specified</small>	

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:	
<input type="checkbox"/> Drug/alcohol diagnosis, treatment or referral information <input type="checkbox"/> Mental health information- including provider notes	<input type="checkbox"/> HIV/AIDS information <input type="checkbox"/> Genetic testing information

Records Release Format and Delivery Method:	
<input type="checkbox"/> Paper <input type="checkbox"/> Electronic	<input type="checkbox"/> Mail to address above <input type="checkbox"/> 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:

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- (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: _____