Tanasbourne Pediatrics, LLC
RAQUEL APODACA, MD
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17895 NW EVERGREEN PKWY, STE 110, BEAVERTON, OR 97066

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____
Please print full name

Address: _____
Street City State Zip

Home/Cell Phone: _____ Work Phone: _____

Release Purpose: □ **Self** □ **Changing Provider** □ **Consultation** □ **Legal** □ **Other:** _____

I authorize Tanasbourne Pediatrics to (check all appropriate boxes, and provide complete name and address information):

□ **Give records to:** □ **Verbally exchange with:** □ **Request records from:**

Name: _____ Phone: _____ FAX: _____

Address: _____
Street City State Zip

Email: _____ My medical information: □ **MAY** or □ **MAY NOT** be faxed

By initialing spaces below, I specifically authorize the release of the following medical records if such records exist:

_____ Chart notes _____ Laboratory reports _____ **PAST 2 YEARS**
_____ Diagnotic imaging _____ Immunization records _____ ALL medical records
_____ Other: _____

Records containing the following information require addtional consent (items must be initialed to be released):

_____ Mental health and ADD/ADHD diagnosis or treatment information _____ Genetic testing
_____ Drug/alcohol diagnosis, treatment, or referral information _____ HIV/AIDS testing

MY SIGNATURE INDICATES THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

I understand that the information used or disclosed in this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that the person or entity I am authorizing to use and/or disclose information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain helath care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I 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.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorziation I must do so in writing except to the extent action has been taken on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

X_____ _____ _____/_____/_____
Signature of Parent/Legal Guardian Print name | Relationship to Patient Date

X_____ _____ _____/_____/_____
Patients 14 years and older-SIGNATURE REQUIRED Print name Date