Orchid Pediatrics

AUTHORIZATION FOR RELEASE OF INFORMATION

Orchid Pediatrics
4850 SW Scholl's Ferry Rd. Ste #301, Portland, OR 97225
(971) 754-1084 email: contact@orchidpediatrics.com

Patient _____ Birth Date_____

I hereby authorize Orchid Pediatrics to (initial those that apply):

(initial)_____ release information to the below-named person, facility or agency

(initial)_____ obtain information from the below-named person, facility or agency

Person/Facility/Agency:_____

Address:_____

City_____State_____Zip Code_____

Phone Number_____Fax Number_____

Email_____

Communication by email represents a potential risk to patient confidentiality. Do we have permission to communicate with this provider by email? **Please circle one:** Yes/No Initial_____

By initialing below, I authorize the release of the following information, including mental health information:

(initial)_____progress notes
(initial)_____evaluation reports
(initial)_____lab results
(initial)_____other (please specify)_____

By initialing and signing below, I specifically authorize release of the following:
(initial)_____mental health information
(initial)_____genetic testing
(initial)_____drug/alcohol diagnosis, treatment, and referral information
(initial)_____HIV/AIDS information

_____
Patient signature (required if 14 years or older) Date

_____
Parent/Guardian/Legal Representative Date

_____
Printed Name and Relationship to Patient

By initialing below, the purpose of information disclosure is **(please initial all that apply):**

(initial)_____ to facilitate treatment and continuity of care
(initial)_____ to facilitate billing and reimbursement
(initial)_____ other (specify)_____

This authorization shall be in force and effect until such time as it is revoked by the patient or patient's representative, or 6 months after discharge from treatment by Orchid Pediatrics, whichever is sooner.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Joy Eberhardt de Master at 4850 SW Scholls Ferry Rd., Suite 301, Portland, OR 97225 or via email at contact@orchidpediatrics.com.

I understand that a revocation is not effective to the extent that Orchid Pediatrics has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Orchid Pediatrics will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to **(please initial both):**

(initial)_____Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law, to the extent the state law provides greater access rights.)

(initial)_____Refuse to sign this authorization.

_____
Patient signature (required if 14 years or older) Date

_____
Parent/Guardian/Legal Representative Date

_____
Printed Name and Relationship to Patient