Pediatric Specialists of Pendleton, LLC
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Physicians
Sara Rickman, MD
Rhonda Wyland, MD

Family Nurse Practitioners
Lynn Lieuallen, RN, FNP
Teri Rosselle, RN, FNP

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION AND RECORDS

This authorization must be written, dated, and signed by the patient or by person authorized by law.

______________________________ (Name of Patient) ______________________________ (Date of Birth)

I hereby authorize the **RELEASE** and/or **EXCHANGE** of medical information specified below regarding the patient named above by copy of medical records and/or by discussing the information in person or by telephone.

FROM ______________________________
ADDRESS ______________________________ **PHONE** ______________________________
CITY, STATE, ZIP CODE ______________________________ **FAX** ______________________________

TO ______________________________
ADDRESS ______________________________ **PHONE** ______________________________
CITY, STATE, ZIP CODE ______________________________ **FAX** ______________________________

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

_____ Medical Records Needed for Continuity of Care (**LAST 3 YEARS**)
_____ Immunization Records
_____ Growth Chart
_____ Other ______________________________
_____ Emergency and Urgent Care Records
_____ Laboratory/Pathology Reports
_____ Diagnostic Imaging Reports
_____ Hospital Summary

Purpose of Disclosure ______________________________

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*Must be **INITIALED** to be included in other documents (how much to disclose, purpose of disclosure and time period must be completed).

_____*HIV/AIDS-related records
_____*Genetic testing information
_____ *Mental health information
_____ *Drug/alcohol information

How much and what kind of information is to be disclosed ______________________________

Purpose of disclosure ______________________________

This Authorization is limited to the following time period ______________________________

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This authorization may be revoked at any time in writing. The only exception is when action had been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request. The information used or disclosed may be subject to re-disclosure by the recipient. Pediatric Specialists of Pendleton, LLC cannot condition treatment or eligibility of benefits on whether this authorization is signed.

______________________________ (date) ______________________________ (Signature of patient)

______________________________ (date) ______________________________ (Signature of person authorized law)

Phone # to be reached ______________________________