AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient name:_____Birth date:_____

Parents name: (if a minor)_____Phone:_____

___RELEASE RECORDS TO Shine Bright Pediatrics

OR

___REQUEST RECORDS FROM Shine Bright Pediatrics

Dr. Uljana Scott **Shine Bright Pediatrics** 20110 SW Alexander St Beaverton, Oregon 97003 Phone: (503)-649-5257	Name:_____ Clinic/Hospital/School:_____ Address:_____ City/State/Zip:_____ Phone:_____Fax:_____

BY INITIALING EACH BELOW you authorize information to be disclosed:
___Recent Medical Records ___History/Physical ___Laboratory Reports
___Radiology Reports ___Clinical Note Charts ___Pathology Records ___Other Records

SPECIAL AUTHORIZATION REQUIRED: You MUST initial each if you want the records below released.

I can cancel this authorization at any time. This will not affect any information that was already disclosed. I understand that the state and federal protects information about my case. I am signing this authorization of my own free will.

I understand that the information used or disposed may be subject to re-disclosure and will no longer be protected by federal law. However, I understand that federal and state laws may restrict re-disclosure of HIV, HIV-related illnesses, AIDS, AIDS related illnesses, Mental Health Treatment, Genetic Testing, Drug/Alcohol diagnosis, and treatment or referral information.

This information will be used for the following purpose
___Establish Patient Care ___Legal ___Review ___Personal Request ___Other_____

By signing below, I acknowledge that I am authorizing and consenting to the release of my medical records. Unless revoked in writing this authorization will remain in effect for 365 days from the date it was signed.

Patient Signature:_____Date:_____
(Patient/Guardian signature if patient is a minor)