Integrative Pediatrics, LLC

Safe passage in a changing world.

Ph. 503.643.2100 FAX 503.643.7300

Authorization to Release Medical Records

____
Patient Name DOB

____
Patient Name DOB

____
Patient Name DOB

____
Patient Name DOB

Purpose of Release: ____

I Authorize: **Integrative Pediatrics, LLC** to release information to ______________________

11790 SW Barnes Rd. Blg. A, Suite 140 ________________________
Address

Portland, OR 97225 ________________________
City, State, Zip

Please Initial the spaces below the records you would like released.

_______ Entire Medical Record ______ Immunizations Only ______ Lab Reports

_______ Pathology Reports _______ Billing Statements

_______ Specific Record (please list)

Separate and Signed authorization form is required for the following:
** HIV/ AIDS related records *Drug/Testing diagnosis, treatment and referral information*
**Mental health information * Genetic Testing*

Recipient other than physicians agrees to pay all charges associated with this request.

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Signature Relation to patient Date