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AUTHORIZATION TO RELEASE/SHARE HEALTH INFORMATION

FROM: Pediatric Cardiology Center of Oregon

(Please include name, address and phone number of the organization you are requesting medical records to be sent.)

TO: _____

_____

_____

_____

Patient Name: _____

Date of Birth: _____

Records requested: _____

_____

Reason for sending: _____

_____

_____
Patient/Parent/legal guardian signature Date

I MAY CANCEL THIS AUTHORIZATION IN WRITING AS ALLOWED BY LAW. THIS WOULD NOT AFFECT ANY ACTIONS ALREADY TAKEN BASED UPON MY ORIGINAL REQUEST. THERE ARE TWO WAYS TO CANCEL THIS AUTHORIZATION: 1) WRITE, SIGN AND DATE A LETTER TO PHYSICIAN OR CLINIC; OR 2) SIGN, DATE AND WRITE "CANCEL" ON ORIGINAL FORM.

WARNING: ONCE WE HAVE DISTRIBUTED YOUR INFORMATION (AT YOUR REQUEST) WE NO LONGER HAVE CONTROL OVER IT. THE RECIPIENT MIGHT RE-DISCLOSE THE INFORMATION; PRIVACY LAWS MAY NO LONGER PROTECT IT.

***This authorization ends one year from date signed, unless otherwise specified.

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