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PEDIATRIC CARDIOLOGY center of oregon

300 N Graham, Suite 250
Portland, Oregon 97227
PH (503) 280-3418
FAX (503) 284-7885

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

FROM: _____

_____

_____

_____

TO: **Pediatric Cardiology Center of Oregon**
300 N Graham St, Suite 250
Portland, OR 97227
FAX: (503)284-7885

Please send copies of medical records regarding:

Patient Name: _____

Date of Birth: _____

Records to be sent: _____

_____

Reason for request: _____

_____

_____
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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Accredited Echocardiography Laboratory