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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 disclosure: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
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.

