



Pediatric Cardiology Center of Oregon

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AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

FROM: **Pediatric Cardiology Center of Oregon**

SEND TO: _____

(Please include the name, phone number, fax number and/or email address of the person or facility receiving the records.)

Patient Name: _____

Date of Birth: _____

Records being requested/sent: _____

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.

