



**Pediatric Cardiology Center of Oregon**  
300 N. Graham St. Suite 250  
Portland, Oregon 97227  
Ph: (503)280-3418  
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[www.pccoforegon.com](http://www.pccoforegon.com)

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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 being requested: \_\_\_\_\_  
\_\_\_\_\_

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.\*\*\*

