SUNSET PEDIATRICS, LLC
9155 SW Barnes Rd., Suite 840
Portland, OR 97225
503-296-7800 fax: 503-291-1584

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____
(Name of Physician/Clinic releasing information TO Sunset Pediatrics)

Physician/Clinic phone#_____ Fax#_____
(This is phone and fax of physician/clinic releasing information **TO** Sunset Pediatrics)

To send records to: **Sunset Pediatrics – 9155 SW Barnes Rd Ste 840, Portland, OR 97225**

To disclose a copy of the specific health and medical information described below regarding:

_____ _____
Name of Patient Date of Birth

This request and authorization applies to:

_____ All healthcare information (if patient is transferring care)

_____ Healthcare information relating to the following treatment, condition, and dates of treatment: _____

_____ Other:_____

For the purpose of: ❒ Changing Physicians ❒ Continuing Care ❒ Other:_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I initial the applicable space next to that type of information.

____ HIV/AIDS information
____ Drug/Alcohol diagnosis, treatment, or referral info
____ Mental health information
____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment of referral information.

You do not need to sign this authorization. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive healthcare services is I the healthcare services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to the Release of Information Coordinator at Sunset Pediatrics and state that you are revoking this authorization.

I have read and understand this Authorization. Unless revoked, this authorization expires the earlier of 180 days fro the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

By:_____ Date:_____
Signature of Patient or Authorized Representative