Authorization to Use/Disclose Health Information

Sunset Pediatrics, LLC – 9155 SW Barnes Road Suite 840 Portland, Oregon 97225
Phone: (503)296-7800 Fax: (503)291-1584 Email: records@sunsetpediatrics.com

Patient Name: _____ **Date of Birth**: _____/_____/_____ **Phone:** (_____) _____

I authorize Sunset Pediatrics to:

Receive ❑ Send❑ **(Choose One)** my specific health information from/to the person(s) listed below:

Clinic/Hospital/Name of Person(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

My health information may be: (check all that apply): ❑ Physically Exchanged ❑ Electronically Exchanged

Indicate the type of information to be released:

❑All healthcare information (if patient is transferring care)

❑Information specific to the following treatment, condition, dates of treatment, or other (please explain):

_____

Reason for Disclosure: ❑Transferring Care ❑Legal ❑Personal Use ❑Insurance ❑ Immunizations Only ❑Other (please explain):

_____

Protected or Sensitive Information

Sunset Pediatrics reserves the right to reject this authorization form if the legal authority of the representative cannot be validated. I understand that certain information cannot be released without specific authorization as required by State/Federal law.

By initialing, I authorize the release of the following protected or sensitive information:
****The following types of sensitive information will NOT be release without INITIALS:**
____ HIV/AIDS Information ____ Birth Control/STI Information ____ Genetic Testing Information
____ Mental Health Information (Incl. ADHD/Developmental Disability Information) ____ Drug/Alcohol Diagnosis, Treatment, or Referral Information

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or 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 if 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 9155 SW Barnes Rd. Suite 840 Portland, OR 97225 Attn: Medical Records Coordinator 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 from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

X _____ X _____ X ____ /____ /____
Signature of Parent or Legally Responsible Person (REQUIRED) | Print Name **AND** Relationship | Date Signed

X _____ X _____ X ____ /____ /____
Signature of Patient if 14+ (REQUIRED) | Print Name | Date Signed

*Rev. 12/2023.