



# Kids First Pediatric Clinic, LLC

18676 Willamette Drive, Suite 300 West Linn, OR 97068

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www.kidsfirstclinic.com

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Parent Name \_\_\_\_\_

I authorize and request that a copy of the following information from my medical record be released as follows:

### RELEASE INFORMATION FROM:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### RELEASE INFORMATION TO:

**Kids First Pediatric Clinic**

**18676 Willamette Dr, West Linn, OR 97068**

**Phone: (503) 699 3313**

**Fax: (503) 699 3365**

\_\_\_\_ Problem List

\_\_\_\_ Progress Notes

\_\_\_\_ History & Physical

\_\_\_\_ Lab Reports

\_\_\_\_ Discharge Summary

\_\_\_\_ Operative Reports

\_\_\_\_ Well Child Checks

\_\_\_\_ X-ray Reports

\_\_\_\_ Emergency Room Record

\_\_\_\_ Immunization Records

\_\_\_\_ other (Please specify) \_\_\_\_\_

I understand that the information released is for the specific purpose state above and may not be provided in whole or in part to any other agency, organization, or person. I further understand that my medical records from other health care providers will not be released with this routine request. **This consent will expire one (1) year after the date of signature.**

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I understand that I may revoke this authorization in writing at any time to the extent that Kids First Pediatric Clinic has already relied on this authorization. I understand that I may revoke this authorization by providing Kids First Pediatric Clinic Release of Information Department a written request for revocation stating my intent to revoke this authorization.

**I will not hold First Pediatric Clinic liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date