

# PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER P.C.

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PDEC is a HIPAA-compliant clinic

<b>PATIENT INFORMATION</b>	
Name: _____	Birthdate: _____
Address: _____	Phone Number: ( ) _____
City: _____ State: _____	Zip: _____

<b>FACILITY/PERSON(S) TO RECEIVE RECORDS</b>	
Name: _____	Phone Number: ( ) _____
Address: _____	FAX Number: ( ) _____
City: _____ State: _____	Zip: _____

<b>FACILITY/PERSON(S) TO RELEASE RECORDS</b>	
Name: _____	Phone Number: ( ) _____
Address: _____	FAX Number: ( ) _____
City: _____ State: _____	Zip: _____

By initialing (please do NOT check mark) the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

By placing my <b>INITIALS</b> in the applicable space next to the type of information, I authorize the following records to be released:
_____ Chart (Progress) Notes
_____ History & Physical
_____ Hospital Reports
_____ Diagnostic/Lab Reports
_____ Other
<b>Forms rec'd without initials will be returned</b>

By placing my <b>INITIALS</b> in the applicable space next to the type of information, I understand and agree that this information will be disclosed:
_____ HIV/AIDS-related information
_____ Drug/Alcohol treatment and/or related information
_____ Genetic Testing information
_____ Mental Health information
<b>Forms rec'd without initials will be returned</b>

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event) \_\_\_\_\_. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

\_\_\_\_\_  
(Signature of Patient/Guardian)

\_\_\_\_\_  
(Date)