PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
PDEC is a HIPAA-compliant clinic

PATIENT INFORMATION

Name: _____ **Birthdate:** _____

Address: _____ **Phone Number:** ( ) _____

City: _____ **State:** _____ **Zip:** _____

FACILITY/PERSON(S) TO <u>RECEIVE</u> RECORDS

Name: _____ **Phone Number:** _____

Address: _____ **FAX Number:** _____

City: _____ **State:** _____ **Zip:** _____

FACILITY/PERSON(S) TO <u>RELEASE</u> RECORDS

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 **INITIALS** in the applicable space next to the type of information, I authorize the following records to be released:	By placing my **INITIALS** in the applicable space next to the type of information, I understand and agree that this information will be disclosed:
_____ Chart (Progress) Notes	_____ HIV/AIDS-related information
_____ History & Physical	_____ Drug/Alcohol treatment and/or related
_____ Hospital Reports	_____ information
_____ Diagnostic/Lab Reports	_____ Genetic Testing information
_____ Other	_____ Mental Health information
Forms rec'd without initials will be returned	***Forms rec'd without initials will be returned***

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)