McKenzie Pediatrics
Records Release Request Form

PLEASE RELEASE RECORDS TO:

☐ Todd A Huffman, MD ☐ Catherine Grenier, MD ☐ Naoko Hokari, MD

Address: **1442 South A Street**
Springfield, OR 97477
Phone: **541-726-4100** Fax: **541-726-4900**

PLEASE RELEASE RECORDS FROM:

Doctor: _____
Address: _____
_____
Phone: _____ Fax: _____

Today's Date: _____

Please transfer records pertaining to my child(ren) listed below:
Child's Name: _____ Birthdate: _____
Child's Name: _____ Birthdate: _____
Child's Name: _____ Birthdate: _____
Child's Name: _____ Birthdate: _____

_____ **Please send written <u>Summary</u> by physician**
_____ **Please send the <u>Entire</u> medical record (all information) to the above Named recipient.**

_____ All hospital records
_____ Laboratory reports
_____ Diagnostic imaging reports
_____ Emergency and urgent care records
_____ Other _____
_____ Clinician office chart notes
_____ Most recent history
_____ Pathology reports

(OVER)

*The following items must be initialed to be included in the use of disclosure of other health information:

_____ *HIV/AIDS related health information and/or records
_____ *Mental health information and/or records
_____ *Genetic testing information and/or records
_____ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal Law prohibits the re-disclosure of such information.) _____
_____

_____ *Psychotherapy notes (If this information is for the use and/or disclosure of psychotherapy notes, then it cannot by combined with any other authorization. **Except to extend that action has already been taken in reliance upon this authorization**, I do understand that I may revoke this authorization at any time by giving written notice to (identify the person/entity to whom written notice must be given) _____ Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert applicable date or event of expiration) _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the above person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual

(A copy of this signed from can be provided to the individual and/or the individual's legal representative upon request.)