COPA
CENTRAL OREGON
PEDIATRIC ASSOCIATES

www.copakids.com
2200 NE Professional Ct.
Bend, Oregon 97701
Phone: 541-389-6313
Fax: 541-389-8760

AUTHORIZATION TO RELEASE AND/OR RECEIVE PROTECTED HEALTH INFORMATION

Autorizacion para divulger y/o recibir informacion de salud protegia

This authorization must be written, dated and signed by the patient or the person authorized by law to give authorization. If the person completing this form is the legal guardian, has legal custody of, or has power of attorney for the patient, the legal document indicating authorization must accompany this request. Completion of this form is voluntary. However, refusal to release necessary medical information may affect eligibility for service.

To our families: We are required by Federal Law to comply with the Health Insurance Portability and Accountability Act (HIPAA). We can help you better if we are able to work with other agencies/individuals that know your child and your family.

I hereby authorize: **(Medical office that is releasing your information)**

NAME OF SENDING OFFICE/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER FAX NUMBER

To disclose to: **(Medical office that is receiving your information)**

Central Oregon Pediatric Associates
NAME OF RECEIVING OFFICE/ORGANIZATION

2200 NE Professional Court
STREET ADDRESS

Bend Oregon 97701
CITY STATE ZIP CODE

541-389-6313 541-389-8760
TELEPHONE NUMBER FAX NUMBER

Records and information pertaining to:

Patient Full Legal Name Date of Birth (MM/DD/YYYY)

MEDICAL RECORD NUMBER DAYTIME PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

INTERNAL USE: (Records will be sent as the following)

- ☐ **Fax #**
- ☐ **Mail to address above**
- ☐ **Pick up**

Type:

- ☐ **Paper**
- ☐ **USB Drive**

The released information will be used for the following purpose(s):

☐ Personal Copy ☐ Continuity of Care ☐ Insurance ☐ Legal/Attorney ☐ Worker's Compensation *from* _____ *to* _____ Other:

CHART NOTES *From* *To*

_____ Birth History Forms _____ Well Child Checks _____ Hospitalizations _____ Growth Grids _____ Immunization Records

PATHOLOGY REPORTS *Name/Type of Test(s)*

LABORATORY RESULTS *Name/Type of Test(s)*

RADIOLOGY REPORTS *Name/Type of Exam(s)*

GENETIC TESTING INFORMATION *From* *To* *Signature* *Date:*

STD, (HIV/AIDS) RECORDS & RESULTS *From* *To* *Signature* *Date:*

MENTAL HEALTH INFORMATION *From* *To* *Signature* *Date:*

☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (Specify):

BEHAVIORAL HEALTH INFORMATION *From* *To* *Signature* *Date:*

☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (Specify):

DRUG/ALCOHOL RECORDS *From* *To* *Signature* *Date:*

☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (Specify):

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 6 months from the date of signing or shall remain in effect for a period reasonably needed to complete the request. I understand that I do not have to sign this authorization in order to receive treatment from Central Oregon Pediatrics Associates. I have the right to refuse to sign this authorization. I also understand that when my information is used or disclosed pursuant to this authorization; it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to the extent that Central Oregon Pediatrics Associations has acted in reliance upon it. My written revocation must be submitted to the Medical Records Clerk at Central Oregon Pediatrics Associates at 2200 NE Professional Ct, Bend Or. 97701

Finally, as is the case with respect to all personal representatives under the Privacy Rule and Oregon State Laws ORS 109.640, ORS 109.610, ORS 109.675, a provider may choose not to treat a parent as a personal representative when the provider reasonably believes, in his or her professional judgment or that the child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

RELATIONSHIP TO PATIENT: ____ Patient ____ Parent ____ Guardian ____ Legal Custody

SIGNATURE/*FIRMA* **DATE/*FECHA***

Printed Name/***Nombre Escrito***

CFR: 164.508 Public Welfare **Revised: 9/28/2018**

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization must be written, dated and signed by the person authorized by law to give the authorization.

To our families: We are required by Federal Law to comply with the Health Insurance Portability and Accountability Act (HIPAA). We can help you better if we are able to work with other agencies/individuals that know your child and your family. Please understand that this could take up to 30 days for processing. **For Personal or Legal use there will be a charge of $25 for the first 10 pages and $0.25 per page after, not to exceed the amount of $50.**

FOR OFFICE USE ONLY:

Notified of Charge:_____ Date Requested by:_____
