
Kids First Pediatric Clinic, LLC
1673 10th St., West Linn, OR 97068
Phone: (503) 699-3313 Fax: (971) 229-4678
email: westlinn@kids1stclinic.com
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**
**1673 10th St, West Linn, OR 97068**

**Phone: (503) 699 3313**
**Fax: (971) 229 4678**

_____Problem List
_____Lab Reports
_____Well Child Checks
_____Immunization Records
_____Progress Notes
_____Discharge Summary
_____X-ray Reports
_____History & Physical
_____Operative Reports
_____Emergency Room Record
_____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