Dr. Mandi's Integrative Pediatrics
503-521-7171 Phone
drmandipediatrics.com

Authorization to Release Information

Patient's Full Name: _____

DOB: _____ Phone: _____

I authorize information to be released by Dr. Mandi's Integrative Pediatrics, LLC and Dr. Anandhi Mandi

To: Clinic Name: _____

Physician Name: _____

Address: _____

Phone : _____Fax : _____

Reason for request:

___ Transfer of care

Medical record include office visits, vaccinations, growth charts, medications, labs, EKG's, radiology results, consult notes etc. (unless otherwise requested)

PROTECTED or SENSITIVE information (Please initial)

___ HIV/AIDS
___Mental health treatment
___Genetic testing
___Alcohol or substance abuse diagnosis/treatment

Permission to fax and/or send electronically – Yes or No

Signature: _____Date: _____

Printed Name _____ Relationship: _____

This authorization is valid for 90 days from the above date and may be revoked by the patient at any time therein.