DR. MANDI'S INTEGRATIVE PEDIATRICS

Authorization to Release Information

Patient's Full Name: _____

DOB: _____ SSN: _____ Phone#: _____

I authorize information to be released (circle one)

TO or **FROM**: Dr. Mandi's Integrative Pediatrics, LLC and Dr. Anandhi Mandi

4950 NE Belknap Ct, #202, Hillsboro, OR 97124

Phone #: _____ Fax#: _____

TO or **FROM**: (Clinic Name):

_____

Physician Name:

_____

Address:

_____

Phone #: _____ Fax #: _____

Type of Information Requested (Please circle)

GENERAL medical records (will be limited to 2 years of information unless otherwise requested) including office visits, vaccinations, growth charts, medications, labs, EKG's, radiology results, etc.

SPECIFIC information only. Please indicate requested information:

_____

_____

_____

PROTECTED or **SENSITIVE** information (Please initial)

___ HIV/AIDS related information including relevant high-risk behaviors

____sexually transmitted diseases

____mental health treatment

____genetic testing

____alcohol or substance abuse diagnosis/treatment

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

Signature of Patient or Guardian: _____ Date: _____

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