DR. MANDI'S INTEGRATIVE PEDIATRICS, LLC

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, ekgs, 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

Dr. Mandi's Integrative Pediatrics, LLC
:: drmandipediatrics.com
:: 4950 NE Belknap Ct#202, Hillsboro, OR 97124
:: Phone: 503-521-7171 Fax: 503-521-7165