

# Integrative Developmental & Behavioral Pediatrics, LLC

## AUTHORIZATION FOR RELEASE OF INFORMATION

Integrative Developmental and Behavioral Pediatrics  
4850 SW Scholl's Ferry Rd. Ste #301, Portland, OR 97225  
(503) 444-1745 email: admin@donnakirchoffmd.com

Patient \_\_\_\_\_ Birth Date \_\_\_\_\_

I hereby authorize Integrative Developmental and Behavioral Pediatrics to (initial those that apply):

(initial) \_\_\_\_\_ release information to the below-named person, facility or agency

(initial) \_\_\_\_\_ obtain information from the below-named person, facility or agency

Person/Facility/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Email \_\_\_\_\_

Communication by email represents a potential risk to patient confidentiality. Do we have permission to communicate with this provider by email? **Please circle one:** Yes/No Initial \_\_\_\_\_

By initialing below, I authorize the release of the following information, including mental health information:

(initial) \_\_\_\_\_ progress notes (initial) \_\_\_\_\_ lab results  
(initial) \_\_\_\_\_ evaluation reports (initial) \_\_\_\_\_ other (please specify) \_\_\_\_\_

By initialing and signing below, I specifically authorize release of the following:

(initial) \_\_\_\_\_ mental health information  
(initial) \_\_\_\_\_ genetic testing  
(initial) \_\_\_\_\_ drug/alcohol diagnosis, treatment, and referral information  
(initial) \_\_\_\_\_ HIV/AIDS information

\_\_\_\_\_  
Patient signature (required if 14 years or older) Date

\_\_\_\_\_  
Parent/Guardian/Legal Representative Date

\_\_\_\_\_  
Printed Name and Relationship to Patient

By initialing below, the purpose of information disclosure is **(please initial all that apply)**:

(initial) \_\_\_\_\_ to facilitate treatment and continuity of care

(initial) \_\_\_\_\_ to facilitate billing and reimbursement

(initial) \_\_\_\_\_ other (specify) \_\_\_\_\_

This authorization shall be in force and effect until such time as it is revoked by the patient or patient's representative, or 6 months after discharge from treatment by Integrative Developmental and Behavioral Pediatrics, whichever is sooner.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Donna Kirchoff at 5319 SW Westgate Dr. Ste #258, Portland, OR 97221 or admin@donnakirchoffmd.com

I understand that a revocation is not effective to the extent that Integrative Developmental and Behavioral Pediatrics has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Integrative Developmental and Behavioral Pediatrics will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to **(please initial both)**:

(initial) \_\_\_\_\_ Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law, to the extent the state law provides greater access rights.)

(initial) \_\_\_\_\_ Refuse to sign this authorization.

\_\_\_\_\_  
Patient signature (required if 14 years or older) Date

\_\_\_\_\_  
Parent/Guardian/Legal Representative Date

\_\_\_\_\_  
Printed Name and Relationship to Patient