The Children's Clinic of Klamath **Incoming Records**

2580 Daggett Avenue
Klamath Falls, OR 97601
541-884-1224
Fax 541-884-1637

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Medical Record # _____
Date of Birth: _____ Home #:_____ Cell#: _____ Work# _____

I authorize Clinic Name: _____

Address: _____

_____

To copy my child's medical records and mail them to The Children's Clinic of Klamath at the above-listed address.

This request is made by the child/parent/legal guardian for the purpose of continuing medical care. Please provide a copy containing all of my child's encounters, immunizations and diagnostic/laboratory results. Specialists names and contact information would be appreciated.

*****If the information you are requesting contains *any* of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. A written release, signed by a child over the age of 13 years is required for the release of any records containing information about mental health or substance abuse. Additionally, if the child is 14 years of age or older they must sign a written authorization for the release of records containing information regarding birth control and/or sexually transmitted diseases. If your child is under age 13, you must initial in the space provided before we are allowed to release records containing information relating to:

_____ HIV/AIDS information.
_____ Mental health information.
_____ Genetic testing information.
_____ Genetic testing information.
_____ Drug/Alcohol diagnosis, treatment, or referral information.

AUTHORIZATION: You are not required to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. This authorization is only applicable to treatment occurring prior to the date of my signature. I understand the patient's health care and the payment for patient's health care will not be affected if I do not sign this form. CCK requires prior medical records to become an established clinic patient unless the care is an emergency.

_____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature or until the requested records have been sent, whichever occurs first, or you may specify a date _____.

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

I have read this authorization, understand and agree with it. By signing this form, you as the parent or guardian are acting *in loco parentis* and warrant that you have the legal authority to act on the Patient's behalf.

_____ _____
Signature: Parent or legal representative Date Signed

_____ _____
Printed Name Description of legal authority
(Please provide legal documentation for guardian's authority)

_____
*****Patient Signature (if required)