KARTINI CLINIC
for Children & Families

3530 N. Vancouver Ave. Suite 400
Portland, Oregon 97227
P: 503.249.8851 F: 503.282.3409

RECORDS REQUEST RELEASE (ROI)

Patient Name: _____ DOB: _____

I authorize Kartini Clinic to <u>obtain</u> medical/mental health records from the following providers and individuals listed below.

Primary Care Provider/Organization	Phone #	Fax #
Mental Health Provider/Organization	Phone #	Fax #
Mental Health Provider/Organization	Phone #	Fax #
Other Health Provider/Organization	Phone #	Fax #

INFORMATION TO BE RELEASED

I specifically authorize the release of the following information:

<u>REQUIRED ITEMS</u>: *(check each box)*

- ☐ Clinical chart notes/food journals
- ☐ Progress notes, flow and growth charts
- ☐ Laboratory, pathology, diagnostic reports
- ☐ Assessments (diagnosis, testing, reports)
- ☐ Psychiatric (notes, medications, referrals)

<u>OPTIONAL ITEMS</u>: *(initial each line and check yes or no)*

_____ ☐ Y ☐ N Drug & Alcohol Information[i]

_____ ☐ Y ☐ N HIV / AIDS Related Test Results & Info.

Information may be transmitted electronically, photo-copied, fax, and/or verbal communication unless noted otherwise below:

Restrictions requested: _____

1. I understand that my records are protected under federal confidentiality regulations (including alcohol and drug and HIV disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The conditions of this form have been explained to me and my questions have been satisfactorily answered. I understand that I am not obligated to sign this consent form, and that I may revoke this authorization at any time with the exception of action already taken based on my previous approval.
2. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.
3. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Kartini Clinic. The Authorization will expire <u>360</u> days from the date signed (or date released / revoked if sooner than 360 days:

Signature: _____

Patient (if 18 years of age or older), *or Legal representative (if patient is less than 18 years of age or in the case of medical guardianship)*

Printed Name	*Indicate relationship if signed by other than patient*	*Date*

[i] If part of the information to be released includes HIV and/or alcohol and drug information, the patient must specifically initial the corresponding section in order to comply with federal and state regulations.