Beth Gallant, D.O.

North River Pediatrics P.C.

Greg Gallant, Clinic Manager
2589 NW Edenbower Blvd
Roseburg, OR 97471
Phone: (541)677-6116
Fax: (541)957-5181
www.nrpeds.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name **Date of Birth** **Phone**

I authorize you to **OBTAIN** health care information **FROM**:

_____
Physician Name

_____
Clinic

_____
Address

_____
City State Zip

_____ _____
Phone Fax

I authorize you to **SEND/DISCLOSE** health care information **TO**:

_____
Name

_____
Title/Organization

_____
Address

_____
City State Zip

_____ _____
Phone Fax

You may use/disclose the following information: (Check all that apply)
___All health care information in my medical record
___Health care information relating to the following treatment or condition: _____
___Health care information for the date(s):_____
___Immunization Information
___Radiology reports Dates or Type: _____
___Other: _____

You may use or disclose health care information regarding testing, diagnosis and treatment for (initial all that apply)
___HIV, HIV-related illness, AIDS, AIDS-related illness ___Drug and/or alcohol use
___Psychiatric disorders/mental health treatment ___Sexually transmitted diseases

Reason for Disclosure
___Referral or second medical opinion- Appointment Date:_____
___Transfer of care ___Insurance application/benefits
___Other: _____

_____ _____
Patient or legally authorized representative signature Date

_____ _____
Printed name if signed on behalf of patient Relationship to patient