PEDIATRIC associates

Authorization to ***OBTAIN*** Healthcare Information

Patient Name:_____Date of birth_____

Mailing Address: _____

Phone:_____Previous name (if applicable)_____

I hereby request and authorize the following release of information:

Information to be released by:

*Organization*_____

Address: _____
_____
_____

Phone _____

Fax: _____

Information to be released to:

Organization: **Pediatric Associates**
Address: **3516 12th Avenue NE Olympia, WA 98506**
Phone: **360-456-1600** Fax: **360-456-6504**

Purpose of disclosure: ( ) continuing care ( ) legal ( ) insurance ( ) at patient request for patient use

( ) other (explain) _____

INFORMATION TO BE RELEASED

The last two years of medical records including immunizations and growth charts will be released unless otherwise indicated

( ) Healthcare information for the following treatment or condition: _____

( ) Healthcare information for the following date(s) _____

( ) All healthcare information ( ) Lab/X-Ray, Specific dates: _____

_____ _____ _____

Date **Signature of patient or authorized rep.** **Relationship to patient**

Release requiring specific consent: My initials and signature below authorize the release of healthcare information related to testing and diagnosis:

_____HIV/AIDS _____Sexually transmitted Disease _____Reproductive care (Minors)

_____Mental Health _____Alcohol/Drug Abuse

Minors: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, any age sexually transmitted diseases (age 13 and older) (2) alcohol and/or drug use (age 13 and older) (3) mental health (age 13 and older)

_____ _____

Date **signature of patient or authorized rep** **Relationship to patient**

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, and enrollment). However, I do have to sign and authorize form (1) to take parent in a research study, or (2) to receive healthcare when the purpose is to create healthcare information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Pediatric Associates based upon this authorization by filling out a revocation form which is available from Pediatric Associates or by writing a letter to Pediatric Associated. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it**.**

This authorization will *expire in 90 days unless a date* is provided below

Date: _____/_____/_____

For Staff: Request has been reviewed and verified as valid meeting criteria of PHI policy and procedure

Initials Date