



Authorization to **RELEASE** 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:

Information to be release to:

Organization: **Pediatric Associates**

Organization: _____

Address: **3516 12th Ave NE Olympia WA 98506**

Address: _____

Phone: **360-456-1600** Fax: **360-456-6504**

Phone _____

Fax _____

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 if provided below

Date: _____ / _____ / _____