Pediatric Healthcare

1420 3RD STREET SOUTH EAST SUITE 200 PUYALLUP, WA 98372

PHONE: (253) 848-7660 FAX: (253) 841-1801

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patients Name: _____ Date of Birth: _____

Previous Name (if applicable): _____ Phone Number: _____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
☐ Pediatric Healthcare	☐ Pediatric Healthcare
☐ _____ Organization / Person Name	☐ _____ Organization / Person Name
_____ Address	_____ Address
_____ City / State / Zip	_____ City / State / Zip
_____ Phone Fax	_____ Phone Fax

Type of Medical Information to be Released:

- ☐ Complete medical record
- ☐ Healthcare information related to the following treatment or dates:

  _____
- ☐ Other: _____

Reason for Request:

- ☐ Personal
- ☐ Transfer of Care
- ☐ Insurance
- ☐ Legal
- ☐ Other: (please explain) _____

This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you do NOT want this information included in the release of your medical record.

- ☐ HIV/AIDS
- ☐ Sexually Transmitted Diseases
- ☐ Reproductive Care
- ☐ Other _____

Minors Age 13-17: 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, pregnancy termination, sterilization, and sexually transmitted diseases, (2) alcohol and/or drug abuse. (3) and mental health conditions.

I hereby consent to the release of the specified information related to the diagnoses, testing, or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understood the contents of this authorization form. My signature below indicates that I herby agree to and authorize the release of patient health information to the above named person or entity. I understand that I have the right to revoke or cancel this authorization in writing at anytime.

There may be a charge for copies of your medical record unless the copies of your health record are being faxed to another physician or healthcare facility.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

This authorization Expires 90 days from the date of signing. Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.