Authorization to Release Patient Health Information

Patient Name _____ Date of Birth _____/_____/_____

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released FROM:	Information to be Released TO:
Sound Pediatrics **Organization**	_____ **Organization**
22180 Olympic College Way NW, #203 Poulsbo, WA 98370 **Address** **City, State, Zip**	_____ **Address** **City, State, Zip**
360-626-4031 **360-626-4037** **Phone** **Fax**	_____ **Phone** **Fax**

Information to be Released

_____ **Limited** transfer of Medical Records to include chart notes from the last **12 months** including problem list, consult notes, medication list, vaccination records, growth charts, lab and radiology reports .

_____ **Complete** Medical Record

_____ **Other** specified information (e.g. specifically dated labs, chart notes etc.)

Purpose of Release

___Continuing care ___Copies for own use ___Transfer to another provider ___Legal ___Coordination with School

___Insurance ___Other_____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Services Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- **This authorization will expire 90-days from the date signed below**.

Signature of Patient and or Legal Guardian

_____ _____

Date Signature of Patient/Legal Guardian

If your child is **13 years of age or older**, Legal Guardian **AND** patient must sign.

_____ _____

Date Signature of Minor Patient

Patient records may contain sensitive information. Please initial to include the following:

___mental health treatment ___sexually transmitted diseases ___AIDS/HIV treatment ___alcohol or drug abuse