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