

CHILDREN'S CLINIC SOUTH SNOHOMISH COUNTY

Authorization to Release Health Care Information

Patient name: _____ Date of birth: _____

I am requesting health care information from:

Name of organization: _____

Address: _____

City/State _____ Zip Code _____

Phone: _____

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

Health care information in my medical record for the date(s): _____

Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this health care information to:

Children's Clinic
21600 Highway 99, Suite 290
Edmonds, WA 98026
425 778 0191
Fax: 425 672 2110

Reason(s) for this authorization

- at my request
- other (specify)

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

in 90 days from the date signed

on (date): _____

when the following event occurs: _____
(no longer than 90 days from date signed)

Cancellation Notice:

Records releases are often accomplished in 2-3 days, but no longer than 15 days. You may withdraw your authorization by one of the following methods:

- Fill out a revocation form. A form is available from Children's Clinic
- Write a letter to Children's Clinic revoking the authorization

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

Last Update: ___/___/___