Authorization to Release Protected Health Information to ABC Pediatrics, PLLC

Patient name: ___________________________________ Date of birth: ____________________________

Previous name: ____

Information to be released from:

Facility or Provider: _______________________________________

Address: _______________________________________

City, State, Zip _______________________________________

Phone: (____)__________ Fax: (____)__________________

You may disclose this health care information to:

ABC Pediatrics, PLLC
1920 Black Lake Blvd SW
Olympia, WA 98512-5651
Phone: (360) 534-9222 Fax: (360) 534-9223

1. **My Authorization**

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

□ All health care information in my medical record (If age 13 or over, please see #2 for additional authorizations needed and the **patient's signature will be required**).

□ 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): ____

2. **Uses and Disclosures Requiring Specific Authorization for Patients–Patient Signature REQUIRED TO RELEASE**

****EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED BY CHECKING BOXES BELOW:**

□ HIV/AIDS (age 14 or older) □ Sexually transmitted diseases (age 14 or older)

□ Mental health or illness (age 13 or older) □ Drug and/or alcohol abuse (age 13 or older)

□ Reproductive Care (age 14 or older)

Patient's signature is **required** on Page 2 if over age 13.

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

□ Legal □ Transfer to another Doctor □ Personal Use

□ Insurance □ School

This authorization ends:

□ on (date): ___________ or when the following event occurs: _________________________________

If an expiration date or event is not specified above, this authorization ends 6 months after the date signed.

3. **My Rights**

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by the releasing party, in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization the purpose was to obtain insurance. 2 ways to revoke this authorization are:

- Fill out a revocation form—at the releasing party's office or
- Write a letter to the releasing party

Protection after Disclosure. I understand that once my health care information is disclosed, ABC Pediatrics, PLLC may redisclose it and that privacy laws may no longer protect it.

____

Legally authorized individual signature (or patient over 18) Date Time

____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

____

Minor patient's signature, if applicable Date Time