

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth _____

Other names records may be under _____

I authorize release of records

FROM: TO:

Practitioner: _____

Facility: _____

Address: _____

Phone: _____

Fax: _____

FROM: TO:

Dr. Kathleen Allen

32331 E Morrison Street

Carnation, WA 98014

Phone 425-333-4600

Fax 425-333-4646

MotherChildMedicine.com

Information to be released:

- Labs _____
- Imaging reports _____
- Surgical reports _____
- Pathology reports _____
- Immunization record
- Growth charts
- Birth Record
- Information pertaining to the following condition and/or treatment:

- Other: _____

EXCLUDE diagnosis, testing, and treatment information related to the following from the records released if initialed below:

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

I understand that my express consent is required to release any health care information relating to testing diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases (STD), psychiatric disorders, or drug/alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, STD's, psychiatric disorders or drug/alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment unless an exclusion is indicated above by my initials.

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party. Revocation of this authorization must be made in writing. I understand that once a practitioner discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under privacy laws.

This authorization expires 90 days after the date it is signed. Copying fee and prepayment may be required.

Patient Signature: _____

Date: _____

Parent/Guardian Signature _____

Date: _____

Office Use Only
Faxed: _____
Initials _____