* Sara Murdoch M.D. Sylvia Morales-Bronner M.D. Phone: 360-456-1600*

 *Beth Harvey M.D Kathy Tran D.O. Fax: 360-456-6504*

 *Lisa Lee M.D. Jaime Plewa ARNP.*

 *Beverly Lirio M.D Wendy Fairall ARNP*

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|  **HIPPA Authorization for Records Release of Healthcare Information****\*\*\*Incomplete forms will not be processed\*\*\*****Patient Information: Doctor: \_\_\_Murdoch \_\_\_ Harvey \_\_\_Lee \_\_\_Lirio \_\_\_Morales-Bronner** **\_\_\_Tran \_\_\_Plewa \_\_\_Fairall****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(Print) First Name Middle Initial Last Name Address City State/Zip Phone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Check appropriate box and give complete name and address information:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To receive records from Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To release records to City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Information to be released:**\_\_\_Vaccine Record \_\_\_ Problem List \_\_\_Medication List \_\_\_Growth Chart\_\_\_Last year of Chart Notes and Lab Results Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Health care information in my medical record relating to the following treatment and condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Records From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specific Information (*please specify):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Patient Authorization:**

I understand that my records may contain information regarding diagnosis or treatment of mental illness, psychiatric treatment, drug and/or alcohol abuse, HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be released. I understand my rights listed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient if over 13 years of age

\*To exclude any of the following information from the records to be released please initial:

\_\_\_\_\_ Mental Illness or Psychiatric diagnosis/treatment \_\_\_\_\_Drug Alcohol abuse/treatment &diagnosis

\_\_\_\_\_HIV/AIDS diagnosis/treatment/testing \_\_\_\_\_Sexually transmitted diseases

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment.) I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may longer be protected under the Privacy Laws.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian Date

This authorization shall remain in effect unless revoked in writing.

A copy of this authorization shall have the same force and effect as the signed original.

**Records Release**