South Sound PEDIATRICS

Authorization to Release Medical Records

Patient's Name: _____ Birth Date: _____
Parent/Guardian's Name: _____ Phone: _____

Address: _____

Release: ☐ **From** ☐ **To**	**Release:** ☐ **From** ☐ **To**
South Sound Pediatrics 3516 12th Ave NE Olympia, WA 98506 Phone: 360-456-1600 Fax: 360-456-6504 ***Records may take up to 15 business days to complete****	Facility: _____ Address: _____ _____ Phone: _____ Fax: _____ Email: _____

Delivery Preference: ☐ Mail ☐ Fax ☐ Pick up at South Sound Pediatrics (if releasing to patient/parent/guardian)

Information Requested (Note: We can only release records from visits in our clinic):

☐ Summary of Care (Immunization history, medication list, problem list)

☐ Last 3 years of Chart Notes

☐ Records regarding the following diagnosis: _____

☐ Other: _____

Purpose of Request: ☐ Moving out of Area/State ☐ Changing practices ☐ Personal ☐ Treatment
☐ Payment/Billing ☐ Legal ☐ Coordination of Care ☐ Other: _____

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

***Disclaimer**: Per Washington state law, if the patient has reached their 13th birthday, only the patient may authorize disclosures relating to sexuality/ reproduction, drug/alcohol use, and mental health.*

Patient 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 for revoking this authorization, please read the Notice of Privacy Practices 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 no longer be protected under Privacy laws. I understand this authorization will expire 90 days from the date signed. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above.

Signature _____ Date signed: _____
Patient or Patient's authorized representative and relationship