

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize:

Provider Name _____

Address: _____

City/State/Zip _____

To release medical records on:

Patient's Name _____ Birth date ___/___/___

(Please print)

Address _____ Phone number _____

As specified below to:

**VALLEY CHILDREN'S CLINIC
4011 TALBOT RD S #220
RENTON, WA 98055
425-656-5300**

Please send the following specific information:

- Medical records from _____ to _____
- Laboratory reports (date) _____
- Other (specify) _____
- OR ALL RECORDS (CHECK HERE)

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

Reason(s) for this authorization (check all that apply):

- at my request other (specify) _____

This authorization ends:

- In 90 days from the date signed on (date) _____ (not more than 90 days)

MY RIGHTS: I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I did, it would not affect any actions already taken by _____ (name of practice or facility) based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I must provide a signed letter to the facility above in order to revoke this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I hereby release the person or entity named above from all legal responsibility that may arise from the act hereby authorized.

Patient or Parent Signature _____ Date ___/___/___

If patient has reached his or her fourteenth birthday only the patient may authorize disclosure relating to sexually transmitted disease.