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)
- ☐ Psychiatric disorders/mental health
- ☐ Sexually transmitted diseases
- ☐ 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.