

AUTHORIZATION TO EXCHANGE PATIENT HEALTH INFORMATION WITH SCHOOL

Patient Name: _____

Seattle Children's Medical Record # (if known) _____ **Date of Birth** ____/____/____

I authorize Seattle Children's Hospital to (check all that apply):

- Obtain information from
 Release information to
 Oral exchange only

School & Contact Person (if known): _____ **Attn:** _____

Address _____

City, State, Zip _____

Phone # (____) _____ **Fax #** (____) _____

Information to be Released to School/Contact:

Dates of service for records release: from _____ to _____

- | | | |
|--------------------------------------------------|-------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Outpatient Clinic Notes | <input type="checkbox"/> Occupational Therapy Reports | <input type="checkbox"/> Physical Therapy Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Speech and Language Reports | <input type="checkbox"/> Nutrition Reports |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> _____ |

Information to be Obtained from School/Contact:

Dates of service for records requested: from _____ to _____

- | | |
|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Psychological Testing/Assessment | <input type="checkbox"/> Medical Treatment Records (including Clinic Notes) |
| <input type="checkbox"/> Pupil Health Records | <input type="checkbox"/> Physical Therapy Reports |
| <input type="checkbox"/> Education Testing/Records | <input type="checkbox"/> Occupational Therapy Reports |
| <input type="checkbox"/> Individual Education Plan (IEP) Special Services Record | <input type="checkbox"/> Speech/Language Reports |
| <input type="checkbox"/> Early Intervention Services Plan | <input type="checkbox"/> Audiology Reports |
| <input type="checkbox"/> Current/Past Medications | <input type="checkbox"/> Other _____ |

If obtaining records from a school, requested records to be sent to:

Seattle Children's Hospital, Attn: _____ Mailstop _____

P.O. Box 5371, Seattle, WA 98145, Phone _____ Fax _____

Seattle Children's: Bellevue Clinic Everett Clinic Federal Way Clinic Olympia Clinic Tri-Cities Clinic

Bellevue at Overlake Medical Tower South Sound Cardiology Pediatric Cardiology of Alaska Odessa Brown

Other _____ *See reverse side for clinic addresses*

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below unless another date or event is entered here _____

Exception: If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days from date signed.

Signature of Patient/Legal Representative	Printed Name
Relationship to Patient	Date Signed
()	Time Signed
Phone Number	

Release Requiring Specific Consent- I specifically authorize Children's to release health information checked below:

- Mental Health/Illness
 Alcohol/Drug Abuse
 Sexually Transmitted Diseases (incl. HIV/AIDS)
 Reproductive Care

Signature of Patient/Legal Representative	Printed Name	Date	Time
-------------------------------------------	--------------	------	------

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

STAFF	<p>Clinic/Unit:</p> <p>For <u>Obtain</u> requests: mail or fax authorization, then place copy in chart. If chart is unavailable, send copy to HIM Filing, A-4902.</p> <p>For <u>Release</u> requests: Do you need HIM Department to send these records? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If YES, send authorization to HIM, A-4902 If NO, place copy in chart, or send copy to HIM Filing, A-4902.</p> <p>Name: _____ Clinic/Unit: _____ Ext: _____</p> <p style="text-align: center; font-size: small;">Please Print</p>
--------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION



52360

**AUTHORIZATION TO EXCHANGE
PATIENT HEALTH INFORMATION WITH SCHOOL**

PATIENT LABEL

Guidelines for completing *Authorization to Exchange Patient Health Information with School form*

Purpose: To ask a school to share information about your child with a Children's health care provider, to have a Children's health care provider share information with someone at your child's school, or both.

Instructions to Staff:

- Check for completeness/legibility of key information:
 - Patient information
 - School contact's name and address
 - Clear indication of information being requested (both release and obtain portions, if appropriate)
 - Complete information about Children's recipient (clinic or provider)
 - Legal representative/patient's signature and contact information
- Complete the staff box, including your signature and department name and extension (to be contacted in case of a question)

What to do with the form:

- For Obtain requests: Mail or fax form to the school contact and
 - Place copy in chart, or
 - If chart unavailable, send to HIM filing (A-4902)
- For release requests, clinic should provide information, if possible
 - Place copy in chart, or
 - If chart unavailable, send to HIM filing (A-4902)
- If you need HIM to send these records, please send to HIM (A-4902) with "yes" box in staff section checked

Guidelines for Families:

Completing the form:

- Please make sure to complete all relevant sections of this form, including:
 - Patient information
 - Detailed name and address of school contact
 - Signature of legal representative/patient, and contact information

Where to take or send it:

- If you complete this form at Children's, give it to a clinic or inpatient unit staff member to send to the Health Information department
- If you are completing this form at home, mail or fax the completed form to the Seattle Children's Health Information department at: PO Box 5371 M/S A-4902 Seattle, WA 98145

Where to call with questions:

- Complete this form in clinic with staff member assistance, or
- Call the Health Information department (206) 987-2173

Additional Information

CONSENT OF MINOR

A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions, (age 13 and older).

FEE FOR COPYING MEDICAL RECORDS

There may be a fee for copying the medical records. Please ask the Release of Information personnel for information about the fee schedule. There will be a charge for copying the entire record.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal and state laws prohibit redisclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Clinic Addresses

Seattle Children's Bellevue at Overlake Medical Tower, 1135 - 116th Ave NE, Suite 400, Bellevue, WA 98004, 425-454-4644, Fax 425-451-0214

Seattle Children's Everett Clinic, 900 Pacific Ave, Suite 100, Everett, WA 98201, 425-304-6080, Fax 425-304-6085

Seattle Children's Federal Way Clinic, 34503 9th Ave S., Suite 300, Federal Way, WA 98003, 253-838-5878, Fax 253-838-1962

Seattle Children's Olympia Clinic, 615 Lilly Road NE, Suite 140, Olympia, WA 98506, 360-459-5009, Fax 360-459-8785

Seattle Children's Tri-Cities Clinic, 969 Stevens, Suite 1B, Richland, WA 99352, 509-946-0976, Fax 509-946-0983

Seattle Children's Bellevue Clinic, M/S CB-21, PO Box 5371, Seattle, WA 98145-5005, 425-454-4644, Fax 425-455-1711

South Sound Cardiology, 1901 South Cedar Street, Suite 103, Tacoma, WA 98405, 253-272-1812, Fax 253-682-1455

Pediatric Cardiology of Alaska, 3260 Providence Drive, Suite 321, Anchorage, AK 99508, 907-261-3655, Fax 907-261-3160

Odessa Brown Children's Clinic, 2101 E. Yesler Way, Seattle, WA 98122, 206-987-7210, Fax 206-987-7206