AUTHORIZATION TO RELEASE / OBTAIN / EXCHANGE PATIENT HEALTH INFORMATION

Requestor: All sections are required in order for Odessa Brown Children's Clinic / Seattle Children's Hospital to process this request

Patient Name: ______________________ Date of Birth ____/____/____

I authorize Odessa Brown Children's Clinic / Seattle Children's Hospital to [☐ Release Information to ☐ Obtain Information from ☐ Exchange Information with] the following Organization / Individual:

Organization/Individual: ______________________ Attn: ____________

Address ______________________

City ____________ State ____________ Zip ____________

Phone # (____) ____________ Fax # (____) ____________

☐ Check this box to receive the information requested in an electronic format on Compact Disc (CD), otherwise paper copies will be sent to the recipient. Electronic records (with the exception of Radiology images) will be password protected. To have the password emailed to you please provide your email address. If no email address is provided the password will be mailed separately to the postal address above.

E-Mail Address: ______________________

Specific Information to be Released / Exchanged / Obtained

Requesting records: from ____________ (Month/Year) **to** ____________ (Month/Year)

☐ Medical treatment records, including clinic notes, history and physical reports

☐ Dental clinic notes	☐ Immunizations	☐ Intake Evaluation/Assessment
☐ Dental films	☐ X-Ray Reports	☐ Psychiatric Evaluation
☐ Growth Charts	☐ Lab/Path Reports	☐ Psychological Testing/Assessment
☐ Prenatal/Birth Records	☐ Current/Past Medications	☐ Educational Records
☐ Treatment Progress/Notes	☐ Treatment Plans/Reviews	☐ Individualized Educational Plan

☐ Other (please specify) ______________________

Purpose of Release / Obtain / Exchange of Information

☐ Continuing care	☐ Copies for own use	☐ Transfer to another provider	☐ Treatment planning
☐ Legal	☐ Coordination with school	☐ Other (please specify) ____________	

Release Requiring Specific Consent

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) mental health conditions (age 13 and older), and 3) Drug and alcohol abuse diagnosis or treatment (this information is subject to Federal Regulation 42 CFR Part 2 - see reverse)
I specifically authorize Children's to release health information checked below:

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

____________ Signature of Minor Patient ____________ Printed Name ____________ Date/Time

Signature Required for Release / Obtain / Exchange of Information

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 (____) ____________ Phone Number ____________ Date & Time Signed

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION
2101 E. YESLER WAY, STE. 100 Seattle WA 98122
Phone: 206-987-2000
Fax Numbers: ☐ 206-329-9764 (Medical Clinic)
☐ 206-987-7206 (Dental/Administration)
☐ 206-987-7275 (Psychiatry)
☐ 206-987-0225 (Health Information Mgt)

PATIENT LABEL HERE

52168

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), 2) drug and alcohol abuse diagnosis or treatment, (age 13 and older) and 3) 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 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.

Drug and Alcohol Abuse and Treatment Records are protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. 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.