

**Staff:** This authorization form does not need to be completed when clinic staff or unit provides the information directly to the legal representative or current outside provider

## AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

**Requestor:** Please read and complete the entire form in order for Children's Hospital to process this request

**Patient Name:** \_\_\_\_\_

**Children's Medical Record #** (if known) \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize Children's Hospital and Regional Medical Center to release information to:

Organization/Individual: \_\_\_\_\_ Attn: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

### Information to be Released to Organization/Individual:

**Dates of service for records requested:** from \_\_\_\_\_ to \_\_\_\_\_

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Discharge Summaries          | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Emergency Department Records |
| <input type="checkbox"/> Lab/Pathology Reports        | <input type="checkbox"/> Clinic Notes      | <input type="checkbox"/> Radiology Films   | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Other (please specify) _____ |  |  |   |

*There may be a charge for copying the patient record, see the reverse side.*

### Purpose of Release:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Continuing care | <input type="checkbox"/> Copies for own use       | <input type="checkbox"/> Transfer to another provider |
| <input type="checkbox"/> Legal           | <input type="checkbox"/> Coordination with school | <input type="checkbox"/> Other (please specify) _____ |

#### 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 Signed

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Mental Health/Illness | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Sexually Transmitted Diseases (incl. HIV/AIDS) | <input type="checkbox"/> Reproductive Care |
|--|---|---|--|

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**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).

*"Non-emergency" release of records may take up to 15 working days. "Emergency" status applies only to records released directly to another healthcare provider for urgent patient care and will be given priority processing.*

**REQUESTOR**

You may:

- Give to clinic or unit staff to forward to Health Information Management Department
- Mail or fax to Health Information Management Department (see address/fax below)
- Hand deliver to Health Information Management Department between 8AM - 4PM.

**STAFF**

Name: \_\_\_\_\_ Clinic/Unit: \_\_\_\_\_ Ext: \_\_\_\_\_  
Please Print

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

# Children's

Hospital & Regional Medical Center

PO BOX 5371 MAIL STOP A-4902  
SEATTLE, WASHINGTON 98105  
PHONE 206-987-2173 FAX 206-987-2061

**AUTHORIZATION TO RELEASE  
PATIENT HEALTH INFORMATION**

White - Chart

Yellow - Legal Representative / Patient

PATIENT LABEL

## Guidelines for completing Authorization to Release Patient Health Information form

**Purpose:** To ask Children's to provide health care information about your child to someone outside of Children's.

### **Instructions to Staff:**

- This authorization form does not need to be completed when clinic staff or unit provides the information directly to the legal representative or current outside provider.
- For other recipients, or where clinic is not able to provide information, send to HIM (A-4902), but first:
- Check for completeness/legibility:
  - Patient information
  - Recipient's name and complete address
  - Clear information about what is requested for release
  - Signature and contact information for legal representative
  - Minor's signature (where required for specific consent)
- If requested, give parent/legal representative directions to HIM department for hand delivery.

### **Guidelines for Families:**

#### **Completing the form:**

- Please make sure to complete all relevant sections of this form, including:
  - Patient information
  - Recipient information
  - Specific information to be released
  - Signature of legal representative/patient, and contact information

#### **Where to send the form:**

- If you complete this form at Children's, give it to a clinic or inpatient unit staff member to send to Health Information department
- If you are completing this form at home, mail or fax the completed form to the Children's Health Information department (address on front)

#### **Where to call with questions:**

- 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.