

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 _____ to _____

- Medical treatment records, including clinic notes, history and physical reports
 Dental clinic notes
 Dental films
 Growth Charts
 Prenatal/Birth Records
 Treatment Progress/Notes
 Other (please specify)
 Immunizations
 X-Ray Reports
 Lab/Path Reports
 Current/Past Medications
 Treatment Plans/Reviews
 Intake Evaluation/Assessment
 Psychiatric Evaluation
 Psychological Testing/Assessment
 Educational Records
 Individualized Educational Plan

Purpose of Release / Obtain / Exchange of Information

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

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)
 206-987-7245 (Dental Clinic)
 206-987-7206 (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.