**Health Information Management**
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pediatrics NORTHWEST PS Mary Bridge Children's

www.pedsnw.net

# AUTHORIZATION FOR PEDIATRICS NORTHWEST, P.S. (PNW) to USE or DISCLOSE MY HEALTH CARE INFORMATION

PATIENTS NAME: _____ DATE OF BIRTH _____

## 1. MY AUTHORIZATION

- You may use or disclose the following health care information (check all that apply):
  - ☐ All Health care information in my medical record
  - ☐ Health care information in my medical record relating to the following treatment, condition or date of service:
    _____
  - ☐ Verbal exchange of information only.
- You may not use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):
  - ☐ HIV (AIDS virus) ☐ Sexually transmitted diseases ☐ Psychiatric disorder/mental health ☐ Drug and/or alcohol use
- You may disclose this health care information to:

  Name (or title) and organization _____ Phone _____

  Address: _____ City _____ State _____ Zip _____
- Reason(s) for this authorization (check all that apply):
  - ☐ At my request ☐ For Marketing Purposes for PNW ☐ Other (specify) _____
  - ☐ PNW will be paid for providing this information for marketing purposes. ☐ Continuity of Care

PNW prices and fees:

• $1.17 per page for the first 30 pages. • $.88 per page thereafter • $26.00 clerical fee to everyone "EXCEPT" the Parent/Patient (when requesting records for self)

- This authorization ends: (This document does not permit disclosure of health care information created more than 90 days after the date it is signed)
  - ☐ In 90 days from the date signed ☐ on (date):_____ ☐ When the following event occurs: _____

## 2. MY RIGHTS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To Take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by PNW based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

1. Fill out a revocation form. A form is available from PNW. OR 2. Write a letter to PNW

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

### Release of information of a Minor

**Under Washington State Law, minors have the right to consent to certain health care treatment and release of records. Please have the patient sign this form if they meet any of the following requirements:**

- If the patient is13 years and older.
- For Mental Health Records – 13 years and older
- If the minor is legally emancipated (legally independent) or married to someone at or above age 18.
- For outpatient drug-and alcohol abuse treatment -13 years and older
- For Birth control and pregnancy-related care - Any age.
- For sexually transmitted diseases, including HIV – 14 years and older

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship to patient

_____ _____

Patient Signature if age 13 years or older Date

If no expiration date is specified, this form expires after 12 months.

_____

Printed name of Patient (please print legibly)