

**AUTHORIZATION to DISCLOSE MY HEALTH CARE INFORMATION to PEDIATRICS NORTHWEST, PS**

Requested of: Name (or title) and organization \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient 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 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:

- 316 Martin Luther King Jr. Way, Suite 212, Tacoma, WA 98405    Attn: \_\_\_\_\_
- 505 S 336<sup>th</sup> St. Suite 210, Federal Way, WA 98003    Attn: \_\_\_\_\_
- 4700 Pt. Fosdick Dr. NW, Suite 211, Gig Harbor, WA 98335    Attn: \_\_\_\_\_
- 1628 South Mildred, Suite 101, Tacoma, WA 98465    Attn: \_\_\_\_\_

• Reason(s) for this authorization (check all that apply);

- At my request     Other (specify)

• 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 is 13 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

\_\_\_\_\_  
Printed name of Patient (please print legibly)