Health Information Management
316 Martin Luther King Jr. Way, Suite 212
Tacoma, WA 98405
253-383-5777 – Phone 253-383-5320 - Fax

pediatrics NORTHWEST PS
Mary Bridge Children's

www.pedsnw.net

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 336th 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 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

_____

Printed name of Patient (please print legibly)