Bainbridge Pediatrics
infancy through adolescence

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name _____ **Date of Birth:** ___/___/___ **Medical Record #**_____

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released FROM:	**Information to be Released TO:**
☐ Bainbridge Pediatrics or	☐ Bainbridge Pediatrics or
☐ _____	☐ _____
Organization	Organization
_____	_____
Street Address City, State, Zip	Street Address City, State, Zip
_____	_____
Phone Fax	Phone Fax

Information to be Released

Dates of service for records request: Beginning _____ **Thru**_____

☐ **Limited** transfer of Medical Records to include the following information:

- Problem List, Medication List, Allergies
- Chart notes for past 12 months
- Vaccination records, Growth charts
- Outside notes / Correspondence
- Lab & Radiology Reports

☐ **Complete** Medical Record (Please check this box if your child has more ***complex medical problems***)

Purpose of Release

☐ Legal ☐ Insurance ☐ Continuing Care ☐ Copies for Own Use ☐ Transfer to Another Provider

☐ Coordination with School ☐ Other_____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- Once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
- This authorization expires 90 days from the date of signature and does not permit disclosure of health information created more than 90 days after the date it is signed.
- There may be a charge for the requested records.

Sensitive Records may require specific patient authorization. Please check applicable box(s) below to request the following records:

☐ **Mental Health Treatment** ☐ **Sexually Transmitted Diseases** ☐ **Aids/HIV Treatment** ☐ **Alcohol/Drug Abuse**

Signature of Patient/Legal Representative

_____	_____	_____
Date	Signature of Patient/Legal Guardian	Relationship to the Patient

Signature of Minor Patient Required for the Following Records

Parents/Legal guardians have the right to full disclosure of their minor child's medical record with the exception of the following which requires authorization of the minor child. Age of Confidentiality Entitlement per RCW 70.02.1230: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS(age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older). If I am a minor patient and would like my parent or guardian to have access to my confidential health care information, my parent's information must be completed in the "Disclose TO" portion of this release at the top of the page.

_____	_____
Date	Signature of Minor Patient