

OLYMPIA PEDIATRICS, PLLC.  
525 LILLY ROAD NE SUITE 250  
OLYMPIA, WA 98506  
AUTHORIZATION TO RELEASE MEDICAL RECORDS

**Patient Information:**

\_\_\_\_\_  
(PRINT name of patient) Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**Information to be released from:**

\_\_\_\_\_  
Name of designated Facility or Provider

\_\_\_\_\_  
Address

**Information to be sent to:**

\_\_\_\_\_  
Name of designated recipient

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

( ) \_\_\_\_\_  
Phone Number

**\*Please note that there is a fee for copying records that are sent from our office**

**Information to be released:**

- ◇ Immunization Records & Growth Chart
- ◇ Summary of Medical Records
- ◇ All Medical Records
- ◇ Specific Information (Please specify):

**Purpose for which disclosure is being made:** (Please mark one of the following)

? Referral      ? Transfer of care      ? Insurance      ? Attorney      ? Other \_\_\_\_\_

**Patient Authorization:**

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS), sexually transmitted diseases, psychiatric disorders/mental health, and drug/alcohol abuse. If I have been tested, diagnosed or treated for HIV (AIDS), sexually transmitted disease, psychiatric disorders/mental health, or drug/alcohol abuse, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

**\*EXCLUDE the following information from the records release (please initial):**

\_\_\_\_\_ Drug Alcohol abuse/treatment & diagnosis      \_\_\_\_\_ Sexually Transmitted Disease  
\_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_\_ Mental Illness or Psychiatric diagnosis/treatment

**Patients Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Notice of Privacy Practices to patients posted at the facility where your information is being released. I understand that 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.

\_\_\_\_\_  
Signature of patient or patient's authorized representative\*

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Relationship to the patient if signed by anyone other than the patient (parent, legal guardian)

**(\*Please provide documents to prove authority to sign on behalf of the patient.)**

If the patient has reached his/her 14<sup>th</sup> birthday, only the patient may authorize disclosures relating to sexuality/reproduction, drug/alcohol use. If patient has reached his/her 13<sup>th</sup> birthday, only the patient may authorize disclosure related to mental health.

This authorization will expire 90 days from the date signed.  
**ALL RECORDS WILL BE DESTROYED AFTER 6 MONTHS IF PATIENT HAS NOT  
ESTABLISHED CARE IN OUR OFFICE**

Rev 9/2008