OLYMPIA PEDIATRICS, PLLC.

Authorization to Release Medical Records

Patient's Name: _____ **Birth Date:** _____

Parent's Name: _____ **Phone:** _____

Address: _____

Release: ☐ **From** ☐ **To**	**Release:** ☐ **From** ☐ **To**
Olympia Pediatrics 3434 12th Ave NE Olympia, WA 98506 (ph) 360-413-8470 (fax) 360-413-8819	Facility: _____ Address: _____ _____ Phone: _____ Fax: _____ Email: _____

Delivery Preference: ☐ Mail ☐ Fax ☐ Secure Email ☐ Pick up at Olympia Pediatrics (if releasing to patient/parent/guardian)

Information Requested:
☐ Complete Records
☐ Provider to Provider Communication

Records Date Range:
☐ From: _____ To: _____
☐ All Dates of Service

Or Specific Records:
☐ Chart Notes
☐ Immunizations
☐ Growth Charts
☐ Medication List
☐ Lab Reports
☐ Imaging Reports
☐ ER/Hospital Reports
☐ Other: _____

Purpose of Request:
☐ Moving out of Area/State
☐ Changing practices
☐ Personal
☐ Treatment
☐ Payment/Billing
☐ Legal
☐ Coordination of Care
☐ Other: _____

Initial:_____ I authorize the release of my STD results and/or HIV/AIDS testing, whether negative or positive, as indicated above. **Definition:** *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 chancroid, gonorrhea, granuloma inguinale, lymphogranloma venereum, genital herpes simplex, chlamydia, trachomitis, genital human papilloma virus infection, syphilis, and human immunodeficiency virus (HIV) infection.*

Initial:_____ I authorize the release of any records regarding drug, alcohol, or mental health treatment, as indicated above.

Disclaimer: If the patient has reached their 14th birthday, only the patient may authorize disclosures relating to sexuality/ reproduction, drug/alcohol use. If patient has reached their 13th birthday, only the patient may authorize disclosure related to mental health.

Patient 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. I understand this authorization will expire 90 days from the date signed. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above.

Signature _____ **Date signed:** _____
Patient or Patient's authorized representative*

Printed Name: _____ **Relationship to Patient:** _____

*Please provide documents to prove authority to sign on behalf of patient

Note: All records will be destroyed after 6 months if patient has not established care in our office.