Authorization to Use or Disclose Protected Health Information

Richmond Pediatrics 357 NW Richmond Beach Rd (Phone) 206-546-2421 (Fax) 206-542-9028

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Richmond Pediatrics may use or disclose the following health care information (check all that apply):

- □ All health care information in medical record
- □ Transfer of care/changing physicians
- □ Health care information in medical record relating to the following treatment or condition: _____
- □ Health care information in medical record for the date(s): _____
- □ Other (e.g., X-rays, bills)—specify date(s): _____

Exchange Information between the following entities:

☐ Exchange/between	☐ To	☐ From	☐ Exchange/between	☐ To	☐ From

_____	Richmond Pediatrics
Organization	Organization
_____	357 NW Richmond Beach Rd Shoreline, WA 98177
Street Address City, State, Zip	Street Address City, State, Zip
_____	206-546-2421 206-542-9028
Phone Fax	Phone Fax

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

- □ at my request
- □ other (specify) _____

This authorization ends:

- □ on (date): _____ □ when the following event occurs: _____
- □ in 90 days from the date signed

To be completed **by the patient**

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (initial all that apply – *If nothing is initialed, this information will NOT be released):*

_____ HIV/AIDS _____ Sexually Transmitted Diseases

_____ Mental Health or Illness _____ Drug and/or Alcohol Abuse

_____ Reproductive Care (minors only)

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

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- to receive research-related treatment in connection with research studies **or**
- to receive health care when the purpose is to create health care information for a third party.

2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Richmond Pediatrics** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form—a form is available from **Richmond Pediatrics** or
   - Write a letter to **Richmond Pediatrics** .

III. **Protection after Disclosure**. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time

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