Richmond Pediatrics

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

Authorization to Use or Disclose Protected Health Information

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
- □ 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): _____
- □ Transfer of care

☐ TO Richmond Pediatrics	☐ FROM Richmond Pediatrics	☐ EXCHANGE between both Entities

_____	Richmond Pediatrics
Organization/Entity	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

This authorization ends:

- □ on (date): _____
- □ when the following event occurs: _____

Expires in one year from the date signed unless otherwise specified

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:
   - 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** .

Other Side -> ->

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

_____

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

IV. To be Completed by Patient -- *Ages 13 – 17 years*

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),
- Mental health or illness (if age 13 and older).

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 checked, this information will NOT be released):*

____ HIV/AIDS ____ Sexually Transmitted Diseases

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

____ Reproductive Care (minors only)

_____

Minor patient's signature Date