University Place Pediatric Clinic
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HIPAA Authorization for Records Release of Health Care Information

*****Incomplete forms will not be processed*****

PATIENT INFORMATION: **Doctor:** ❑ Davies ❑ Ludke ❑ Ost ❑ Skarzynska ❑ Struthers

_____ DOB: _____
(PRINT) First Name Middle Initial Last Name

_____
Address City State/Zip Phone

If records need to be sent, check the box and give complete name and address information:

❑ To send records to: Name: _____

Address: _____

City/State: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED:

❑ Medical records from most recent 2 years.
❑ Health care information in my medical record relating to the following treatment or condition:

_____

❑ Medical Records from _____ to _____
❑ Specific Information *(please specify):* _____

PURPOSE for Which Disclosure is Being Made: (Check only one):

❑ Changing doctor ❑ Self (A fee will be assessed for records requested for personal use. Please consult the clinic for policy.)
❑ Insurance ❑ Attorney/Legal ❑ Other: _____
❑ **MOVING: (new address & ph):** _____

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of mental illness, psychiatric treatment, drug and/or alcohol abuse, HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be released. I UNDERSTAND MY RIGHTS LISTED BELOW.

_____
Signature of Patient if over 13 years of age

*** To EXCLUDE any of the following information from the records to be released please initial:**

Mental Illness or Psychiatric diagnosis/treatment _____ Drug Alcohol abuse/treatment & diagnosis _____

HIV/AIDS diagnosis/treatment/testing _____ Sexually transmitted diseases _____

PLEASE NOTE: ANY OF THE ITEMS INITIALED ABOVE WILL NOT BE INCLUDED WITH RECORDS.

My 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 of revoking this authorization, please read the Privacy Notice 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 Parent or Legal Guardian/Representative **Date**

This authorization shall remain in effect until request is fulfilled.
A copy of this authorization shall have the same force and effect as the signed original.

RECORDS RELEASE - ESTABLISHED PT OUTGOING