Ballard Pediatric Clinic
7554 15th Ave NW, Seattle, WA 98117 – p: 206.783.9300 f: 206.315.8848
Authorization to Use or Disclose/Release/Obtain Protected Health Information

NOTE: IT CAN UP TO TWO WEEKS TO PROCESS A RECORDS TRANSFER

Patient name: _____ Date of birth: _____

I. My Authorization

You may use, disclose or release the following health care information (check all that apply):

- o **ALL** health care information in the patient's medical record
- o Health care information in my medical record relating to the following treatment or condition:

  _____
- o Health care information in my medical record for the date(s): _____
- o Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (must check all that apply):

- o HIV (AIDS virus)
- o Psychiatric disorders/mental health
- o Sexually transmitted diseases
- o Drug and/or alcohol use

Ballard Pediatric Clinic may DISCLOSE this health care information TO:

Name, Facility, Organization, Physician (or name of parent if minor): _____

Address_____City_____State___Zip_____Fax_____

Ballard Pediatric Clinic may OBTAIN information FROM:

Name, Facility, Organization, Physician (or name of parent if minor): _____

Address_____City_____State___Zip_____Fax_____

Reason(s) for this authorization:

o transfer care o personal use o mutual exchange of information

This authorization ends: o Never

- o on (date): _____ o when the following event occurs: _____
- o in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

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

- To take part in a research study **or**
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Ballard Pediatric Clinic based upon this authorization. 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 Ballard Pediatric Clinic, **or**
- Write a letter to Ballard Pediatric Clinic.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Signature of Patient, Parent or Legally authorized individual Date

_____

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