

University Place Pediatric Clinic, P.S.

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08-08

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HIPPA Authorization for Release of Health Care Information

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

PATIENT INFORMATION: Doctor: Davies DeBusschere Hautala Rone Struthers

DOB: _____

(PRINT) First Name Middle Initial Last Name

Address City State/Zip Phone:

Check appropriate box and give complete name and address information:

To send records to Name: _____
 To receive records from Address: _____
 To verbally exchange with City/State: _____
Phone: _____ Fax: _____

INFORMATION TO BE RELEASED:

_____ All health care information in my medical record
_____ Health care information in my medical record relating to the following treatment or condition:
_____ Medical Records from _____ to _____
_____ Itemized billing statement 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 unless revoked in writing.

A copy of this authorization shall have the same force and effect as the signed original.