

Peninsula Children's Clinic, Inc.
902 East Caroline Street
Port Angeles, WA 98362
Phone: (360) 457-8578
Fax: (360) 457-4841

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient's Legal Name: _____ Date of Birth: _____

Current Address: _____ Phone: _____

Please include my other children (please include full names and dates of birth):

1. _____

2. _____

Please **SEND** my records to:
Facility or Doctor's name:

Please **GET** my records from:
Facility or Doctor's name:

Address

Address

Phone Fax

Phone Fax

_____/_____
/

_____/_____
/

This request applies to:

___ All health care information **OR**

___ Specific diagnosis / treatment dates: _____

Information to be used for the purpose of:

___ Transfer of care ___ Continuity of care ___ Attorney use ___ Personal (fee may be required)

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

EXCLUDE the following information from the records:

___ Sexually transmitted disease ___ HIV/AIDS diagnosis/treatment/testing
___ Mental illness/Psychiatric diagnosis/treatment ___ Drug/alcohol abuse/treatment and diagnosis

I understand that I do not have to sign this authorization in order to obtain health care. I may revoke this authorization, except to the extent that information has already been released in reliance of this consent, by writing a letter to Peninsula Children's Clinic. I understand that once health care information that I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient/Representative Date

Relationship Status (if signed by anyone other than patient)