Authorization to Release Information

Creekside Medical

900 NE 139th Street, Suite 202 Vancouver, WA 98685
PHONE: 360-566-9355 **FAX:** 360-816-1327

Patient name: _____ Date of Birth: _____

Preferred name: _____ Parents' Names: _____ Phone: _____

Creekside Medical may

☐ **OBTAIN** my healthcare information from: **OR** ☐ **SEND** my healthcare information to:

Name or organization: _____

Email (Preferred): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I. Information to be disclosed or received: (check all that apply):

☐ Immunization Record(s)
☐ Most recent clinic note, date: _____
☐ All Progress Notes, Last 3 years
☐ Other: _____
☐ EKG
☐ Laboratory Tests, Last 3 years
☐ Radiology / Imaging, Last 3 years

***SENSITIVE RECORDS MAY REQUIRE PATIENT AUTHORIZATION**. Please initial all spaces of records **you want to obtain/send**. Records containing the following information require consent from the minor (items must be initialed to be released):

_____ Behavioral or Mental Health/ADHD & ADD (13 and older)
_____ Reproductive health care (all ages)
_____ HIV/AIDS (14 and older)
_____ Sexually Transmitted Disease (14 and older)
_____ Drug/alcohol abuse/diagnosis & treatment (13 and older)
_____ Genetic Testing

MINOR'S SIGNATURE: _____

Under Washington state law, minors may have the right to consent to certain types of care at certain ages, without parental consent, and in those cases, generally only the minor may authorize the use and disclosure of the related medical records.

II. Description of purpose of the use and/or disclosure:

☐ Transfer of Care / New PCP ☐ Consult / Specialist ☐ Insurance Claim
☐ Legal / Attorney Review ☐ Personal Use ☐ Other: _____

I authorize the transfer of my health care information to or from the above address. I understand that no charge will be made for transfer of information to another health care facility. However, if health care information is transferred to me, my family member, another person or third party such as an attorney or insurance company, the charge will be $28.00 plus $1.24 per page for the first 30 pages, and $0.94 per page after 30 pages. Payment is due before records are rendered.

III. My Rights

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand the person or organization that receives it may re-disclose it – privacy laws may no longer protect it. I may revoke this authorization in writing at any time. This authorization expires 90 days from the date it was signed.

_____ _____ _____
PATIENT'S SIGNATURE if 13 years or older* Date Time

_____ _____
PARENT OR LEGAL GUARDIAN SIGNATURE Relationship (parent or legal guardian)

Permission to use secure email: _____ (Patient/Guardian Initials) Email address: _____