COLUMBIA BASIN PEDIATRICS
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS FORM MUST BE COMPLETED IN FULL BEFORE RECORDS CAN BE RELEASED

PATIENT'S NAME: _____
LAST FIRST MI
BIRTHDATE_____ **SOC. SEC.#**_____ **PH#**_____

RELEASE TO: _____
_____
_____

RELEASE FROM: _____
_____
_____

( ) Medical Records (Date)_____
( ) X-rays (Reports)_____
( ) EKG's (Date) _____
( ) Laboratory (Date) _____
( ) Other _____

READ CAREFULLY:

I authorize _____ to furnish all requested medical information to the person or entity named above. **

I understand that my express consent is required to release information relating to sexually transmitted diseases, AIDS and/or HIV status, mental illness and/or psychiatric treatment, and/or drug/alcohol abuse.

If I have been tested, treated or diagnosed in connection with any sexually transmitted disease, AIDS and/or HIV status, or drug/alcohol abuse, mental illness and/or psychiatric treatment, you are **specifically authorized to release** to the person or entity named above all information or medical records relating to such diagnosis, testing or treatment.
( ) yes ( )no

I understand that once released, the releaser cannot limit or control the subsequent use or dissemination of the information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release the person or entity named above and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized.

** Except for third party payors of medical bills, Washington law limits the effectiveness of this release to a maximum of 90 days from the date the release is signed.

PATIENT'S SIGNATURE_____**DATE**_____
IF MINOR, PARENT OR LEGAL GUARDIAN SIGNATURE:
_____

IF A PATIENT HAS REACHED HIS OR HER FOURTEENTH BIRTHDAY <u>ONLY</u> THE PATIENT MAY AUTHORIZE DISCLOSURE RELATING TO SEXUAL DISEASE.
COMMENT _____

SIGNATURE _____