Washington University Clinical Associates

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- AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIED HEALTH INFORMATION

PATIENT INFORMATION:

Name: _____ Birth Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

RELEASE INFORMATION FROM:

Name: _____

Address: _____

City: _____ State_____Zip:_____

Phone: _____ Fax:_____

RELEASE INFORMATION TO:

Name: _____

Address: _____

City: _____ State_____Zip:_____

Phone: _____ Fax:_____

PURPOSE FOR THE RELEASE OF INFORMATION:

☐ Transferring to Adult Practice ☐ Visit to a specialist
☐ Attorney Use ☐ Personal Use
☐ Transferring to another Pediatric Practice
☐ Other (describe)_____

*Please be advised, records can take up to 2 weeks to process. We will transfer medical records once at no charge. For all other request including subsequent transfers a processing fee, a fee per page and postage and handling will be charged before records are sent. This fee is determined by the state each year. Please call our medical records department to get the current fee schedule.

DESCRIPTION OF INFORMATION BEING RELEASED:

I would like (choose one):
☐ Complete Health Record
☐ Diagnostic reports (labs, x-ray, etc.)
☐ Billing Records
☐Specific date(s) of service:
From_____To_____
☐ Other: _____

_____

SENSITIVE INFORMATION RELEASE: I understand if my medical record or billing record contains information that references drug/alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release.

I hereby authorize SOUTHWEST PEDIATRICS-WUCA, to use or disclose protected health information regarding my child's care and treatment. I understand that information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV- related information, the recipient is prohibited from disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who receive or use my HIV- related information without authorization.

I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed below, except to the extent SWP –WUCA has already relied upon this authorization. Signing this authorization is voluntary. SWP-WUCA may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms of this document. If you do not agree with any part of this document, you may speak to the privacy officer.

- If the patient is 18 years of age or older, the patient must sign and date the form
- If the patient is 18 years of age or older and is incapable of signing, a substitute who is legally authorized may sign and date the form. You must indicate your legal authority after your signature.
- If the patient is 17 years of age or younger, a parent or legal guardian must sign and date the form, unless there is an exception under state or federal law.

Signature:_____

☐Self ☐Parent ☐Guardian ☐Other_____ **Date:**_____/_____/_____

Unless revoked, this Authorization will expire 90 days from date of signature, unless otherwise specified.