Washington University Clinical Associates

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Non Minor Patient Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

The number listed below is the number in which I would like SOUTHWEST PEDIATRICS-WUCA to contact me:

Phone #: _____

☐ By checking this box, I give SOUTHWEST PEDIATRICS-WUCA permission to use and/or disclose pertinent health information for school, sport or camp forms and to securely fax such information as requested by myself, school or my parents/guardians if specified below.

ACKNOWLEDGEMENT OF RECEIPT OF SOUTHWEST PEDIATRICS-WUCA, NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of SOUTHWEST PEDIATRICS-WUCA Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize SOUTHWEST PEDIATRICS-WUCA to disclose my medical information so that the practice may treat me, seek payment from third parties for such treatment, and generally carry on the practice's health care operations (e.g., quality assurance). I also authorize SOUTHWEST PEDIATRICS-WUCA to disclose my medical information to insurers and providers outside of the practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

☐ I **DO** authorize SOUTHWEST PEDIATRICS-WUCA to disclose my medical information (including Mental Health information) to the family members/legal guardians listed below:

_____
Name of parent/guardian Relationship

_____
Name of parent/guardian Relationship

☐ I **DO NOT** authorize SOUTHWEST PEDIATRICS-WUCA, to disclose my health information to anyone other than myself. (I understand I may instruct SOUTHWEST PEDIATRICS-WUCA, to limit disclosure of my health information to family members and/or their insurance plans but by doing so my family's health plan cannot be billed for my visit or test and I shall be financially responsible to pay all charges directly).

_____ _____
Patient Signature Date

_____ _____
Witness Date

This form may be amended or revoked by patient at any time. This form is valid for a period of one year, unless amended or revoked.