Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My Authorization**

I voluntarily consent authorization to use or disclose the following healthcare information: (check all that apply)

* Medication refill requests
* Pick up prescriptions and/or completed forms
* Schedule an appointment and/or facilitate medical care
* Most recent physical exam, immunization, growth chart, summary of significant and/or chronic treatment.
* All healthcare information in my medical record -requesting printed records (charges may apply).
* All healthcare information in my medical record -requesting verbal communication only, no printed records.
* Only the following type of health information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may disclose healthcare information regarding testing, diagnosis, and treatment for (check all that apply)

* HIV (Aids Virus)
* Psychiatric Disorder/mental health
* Sexually transmitted diseases
* Alcohol and/or drug use

**You may disclose this healthcare information to:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This Authorization ends:** **(*This document does not permit disclosure of health information created more than 24 MONTHS after the date it is signed.*)**

**My Rights**

I understand that I may revoke this authorization at any time by notifying Mercer Island Pediatrics in writing. If I choose to do so, my revocation will not affect any actions taken by Mercer Island Pediatrics before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

I understand that my health care provider cannot guarantee that the receipt will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Please fill out the contact information below for any further correspondence:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Responsibility Agreement and Assignment of Insurance Benefits**

I hereby authorize my signature on all insurance claim forms at Mercer Island Pediatrics for payment directly to them for services rendered. I authorize Mercer Island Pediatrics to release any health care information necessary to my child by Mercer Island Pediatrics. I understand that I am responsible for charges incurred regardless of whether my insurance pays. I understand that the office policy requires payment in full when paying out of pocket at time of service unless other arrangements have been made. I understand and agree that any unpaid balance over 120 days may be assigned to a third-party collection’s agency. I understand and agree to the above items.

* I intend to continue financial responsibility for the patient listed above.
* I do not intend to continue financial responsibility for the patient listed above.

Check only one:

* This consent is ongoing and shall remain in effect until revoked in writing by the undersigned.
* This consent shall remain in effect until the patient above reaches the age of \_\_\_\_\_\_\_\_\_\_\_\_.
* This is for services rendered on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_