18 Years of Age and Older Parent Authorization for Mercer Island Pediatrics
To Use or Disclose My Healthcare Information

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
- ☐ Only the following type of health information: ____

  ____

You may disclose this healthcare information to:

Name : ____

Address: ___________________________ City: ___________________ State: ___________ Zip:___________

Purpose for this authorization: (check all that apply)

☐ At my request ☐ Other (specify)___________________________________

This Authorization ends: (*This document does not permit disclosure of health information created more than 90 days after the date it is signed*.)

☐ In 90 days from the date signed ☐ on (date): ________________________________
☐ When the following event occurs: ____
(no longer than 90 days from date 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.

____________________________________ ____________________________________
Patient or legally authorized individual signature Date

____________________________________ ____________________________________
Printed name if signed on behalf of patient Relationship (parent, legal guardian, etc)