**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 one box**)

* Most recent physical exam, immunization record, growth chart, summary of significant and/or chronic problems, allergies and current medication. (**PREFERRED BY MIP FOR PRINTED RECORDS)**
* Only the following records or types of health information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ALL healthcare information in my medical record-**requesting printed records (charge may apply)**
* ALL healthcare information in my medical record-**verbal communication only, no printed records**

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

* HIV (AIDS virus) □ Psychiatric disorders/mental health
* Sexually transmitted diseases □ Drug and/or alcohol use

You may disclose this healthcare information to:

Name (or title) or organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of release: □ My request □Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* In 24 months from the date signed □ On (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When the following event occurs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(no longer than 24 months 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.)