Authorization for Child & Adolescent Clinic to Obtain or Send My Health Care Information

Patient name: _____ Date of birth: _____

Parents' names: _____

The Child and Adolescent Clinic may:

☐ **OBTAIN my healthcare information from:** ☐ **SEND my healthcare information to:**

Name or organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I. My Authorization

The Child and Adolescent Clinic may obtain or send the following health care information (check all that apply):

☐ Standard set of Health Care Information (such as Visits, Immunizations, Medications)

Special Permission required for:

☐ Information regarding ADD and ADHD _____ Initials

☐ All psychiatric/mental health information, plus drug/alcohol use information ____ Initials

☐ All health care information regarding testing, diagnosis, and treatment for

(check all that apply): ☐ HIV (AIDS virus) ☐ Sexually transmitted disease ____ Initials

☐ Limit information to specific date or diagnosis: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Child & Adolescent Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Child & Adolescent Clinic or
- Write a letter to the Child & Adolescent Clinic.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

- If my healthcare information is used for marketing purposes.
- If payment or something of value is received for my healthcare information to be used for marketing purposes.

III. This authorization ends: *(This document does not permit disclosure of health information created more than 90 or 180 days after the date it is signed.)*

Clinician Name:

☐ 90 days from the date signed below

☐ 180 days from the date signed below

Child and Adolescent Clinic
971 11th Avenue
Longview, WA 98632

Phone – 360-577-1771
Fax – 360-423-9537

I authorize the transfer of my health care information **to or from** the above address. I understand that **no charge will be made for transfer of information to another health care facility**. However, if health care information is transferred to myself, my family member, or another person, the charge will be $28.00 plus $1.24 per page for the first 30 pages, and $0.94 per page after 30 pages. Sales tax will be an additional 8.1%. Payment is due when records are picked up.

_____ _____

Patient's signature if 16 years or older (13 years for mental health) **Date** **Time**

_____ _____

Parent or legal guardian signature if patient is less than 16 years of age **Relationship** (parent or legal guardian)

_____ _____ ☐

Parent or Patient Authorization Received by Phone – **Witness #1** **Date** **Time**

_____ _____

Parent or Patient Authorization Received by Phone – **Witness #2** **Date** **Time**