HopeCentral Pediatrics & Behavioral Health – Authorization to Disclose Protected Health Information

Patient Name:

Date of Birth: Patient ID:

Information to be disclosed:

☐ All records

☐ Last two years of records

☐ Immunization records

☐ Psychological records

☐ Bills or payment records

☐ Imaging reports or films (please specify):

☐ Other, type of records and dates:

This protected health information is disclosed for the purpose of: ☐appointment ☐billing ☐care coordination ☐transfer of care ☐Other:

I hereby authorize the staff of HopeCentral to disclose my health information TO:

TO:	Name of person or organization: Address: City: State: Zip: Phone: Fax:

I hereby authorize the staff of HopeCentral to get my health care information FROM:

FROM:	Name of person or organization: Address: City: State: Zip: Phone: Fax:

*Note to sender: Records should be **faxed to (206) 723-1701** or **mailed to HopeCentral, 3826 S. Othello, Seattle, WA 98118***

This Authorization is valid for 365 days unless a different expiration date is indicated here: _____

I understand that this Authorization to Release of Information and/or Designation of a Representative allows only the actions specified above and does not include the ability to make decisions concerning my healthcare.

I understand the information to be released or disclosed may include information relating to my mental health, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse and other areas (i.e. domestic violence) as it applies to my treatment. I authorize the release or disclosure of this type of information.

I understand that I may revoke this Authorization to Release of Information at any time, except to the extent that action has been taken in reliance upon it, by submitting a request in writing to HopeCentral. I understand that the person/entity I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect the information.

If signed by Legally Authorized Representative: Representative Relationship: ☐ Parent ☐ Guardian ☐ Other:

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Print Name

HopeCentral