Authorization for *Pediatric Associates of Whidbey Island* to Obtain or Send My Health Care Information

Patient name: _____ Date of birth: _____

Parents' names: _____

***Pediatric Associates of Whidbey Island* may:**

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

Name or organization: _____

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

Phone: _____ Fax: _____

I. My Authorization

***Pediatric Associates of Whidbey Island* may obtain or send the following health care information (check all that apply):**

☐ Specific Information: _____

☐ Transfer of care to _____

☐ All health care information

☐ Communication regarding behavior and learning: _____

☐ All psychiatric and mental health information, plus drug and alcohol use information

☐ All health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus) ☐ Sexually transmitted disease

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 *Pediatric Associates of Whidbey Island* 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 *Pediatric Associates of Whidbey Island* or
- Write a letter to *Pediatric Associates of Whidbey Island.*

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

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.)*

☐ 90 days from the date signed below

☐ 180 days from the date signed below

Physician Name:

Pediatric Associates of Whidbey Island Ph: (360) 675-5555
275 SE Cabot DR #B-102 Fax: (360) 675-0275
Oak Harbor, WA 98277

*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 me, my family member, or another person, the charge will be $25.00 plus $1.12 per page for the first 30 pages, and $0.84 per page after 30 pages, plus sales tax. 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) ☐