MEDICAL RELEASE/AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION
North Sound Pediatrics

Patient's Name: _____Date of Birth: _____

Address: _____

Phone #: _____

AUTHORIZATION:

☐ I authorize North Sound Pediatrics to release or obtain protected health information of the above-named patient.

TYPE OF RECORDS REQUESTED:

☐ All Medical Records ☐ Immunization Records ☐ Billing Records
☐ Records related to a specific illness or injury: _____
☐ Records for the following date(s): _____
☐ Other: _____

PURPOSE FOR THIS REQUEST:

☐ Personal ☐ Transfer of Care ☐ School ☐ Legal ☐ Other: _____

HOW SHOULD NORTH SOUND PEDIATRICS HANDLE THIS REQUEST?

☐ Please give patient's records to me in person

☐ Please mail patient's records to me at the address above

☐ Please **request** patient's records **from** the following:

_____
Name of Provider/Facility/Individual

_____
Address

_____
City/State/Zip

_____
Phone # / Fax #

☐ Please **send** patient's records **to** the following:

_____
Name of Provider/Facility/Individual

_____
Address

_____
City/State/Zip

_____
Phone # / Fax #

I UNDERSTAND THAT:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form for treatment or payment.
- I can cancel this authorization at any time by writing to North Sound Pediatrics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire one year from the date signed below.
- In accordance to Washington State Department of Health, North Sound Pediatrics has the right to charge for copying medical records. The fees set by the State are $23 for clerical fees, $1.02 for each page up to 30 pages and $0.78 for each additional page. There may be a charge for the requested records.

_____ _____
Printed Name of Person Completing Form **Relationship to Patient**

_____ _____
Signature of Person Completing Form **Date**

Disclaimer: This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.

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