

# 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):**

Specific Information: \_\_\_\_\_

Communication regarding behavior and learning: \_\_\_\_\_

All health care information

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 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.)*

90 days from the date signed below

180 days from the date signed below

Child and Adolescent Clinic    Phone – 360-577-1771  
971 11<sup>th</sup> Avenue                      Fax – 360-423-9537  
Longview, WA 98632

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 \$23.00 plus \$1.04 per page for the first 30 pages, and \$0.79 per page after 30 pages. 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)