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: ____

☐ Most recent clinic note

☐ 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 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 $26.00 plus $1.17 per page for the first 30 pages, and $0.88 per page after 30 pages. Sales tax will be an additional 8.9%. 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**