

# 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):**

Standard set of Health Care Information (such as Visits, Immunizations, Medications)

**Special Permission required for:**

Information regarding ADD and ADHD \_\_\_\_\_ Initials

All psychiatric/mental health information, plus drug/alcohol use information \_\_\_\_\_ Initials

All health care information regarding testing, diagnosis, and treatment for  
(check all that apply):     HIV (AIDS virus)     Sexually transmitted disease

Limit information to specific date or diagnosis: \_\_\_\_\_

**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    Phone – 360-254-7750  
2121 NE 139<sup>th</sup> St, Ste 400    Fax – 360-546-5875  
Vancouver, WA 98686

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 \$28.00 plus \$1.24 per page for the first 30 pages, and \$0.94 per page after 30 pages. Sales tax will be an additional 8.1%. 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