Woodinville Pediatrics
www.woodinvillepediatrics.com

17000 140th Ave NE, Suite 102
Woodinville, WA 98072
Phone: (425) 483-5437 Fax: (425) 488-4919

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

❒ I authorize Woodinville Pediatrics **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

❒ I authorize Woodinville Pediatrics **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ❒ Healthcare ❒ Insurance coverage ❒ Personal ❒ Other ❒ Transfer of Care

TYPE OF RECORDS REQUESTED:

❒ Immunization History ❒ All Records ❒Include records submitted to Woodinville Pediatrics.
❒ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

❒ Records for the following date(s)_____
❒ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
❒ Specific information (Select one or more, as applicable)
- ❒ Procedure report ❒ History & physical ❒ Physical Therapy ❒ Laboratory test results
- ❒ X-ray reports ❒ Sports Forms and Medication Forms to Schools:_____
- ❒ Other:_____
(Please describe.)

❒ Entire copy of the record checked above.

YOU MAY DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS, AND TREATMENT FOR (INITIAL ALL THAT APPLY):

❒ HIV (AIDS virus)_____ ❒ Psychiatric disorders/Mental Health_____
❒ Sexually transmitted diseases_____ ❒ Drug/Alcohol use_____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed..
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Printed Name of Patient or Representative_____.

Relationship to Patient (if requester is not the patient)_____

Request expires one year from the date the Authorization is signed.