Authorization for *Boyer Children's Clinic* to Use or Disclose Protected Health Information

Childs Name: _____ Date of Birth: _____
(Last Name) (First Name) (MI)

Previous Name: _____

I. My Authorization

Information released to/from: **Boyer Children's Clinic**
(Circle one or both to/from **1850 Boyer Avenue East, Seattle, WA 98112**

Information sent to/from: _____
(Circle One or Both To/From) (Name/Agency of designated recipient)

_____
(Address)

_____ **( )** **( )**
(City/State/Zip) (Phone Number) (Fax Number)

Information to be released:

☐ IFSP
☐ The most recent 2 years of pertinent information*
☐ All medical records
☐ Specific Information (Please specify): _____

*Pertinent information includes types of records where your child has received care such as hospitals, agencies, speech, occupational and physical therapy, school district, psychiatric, eye doctor, primary physician, insurance, social work or other counseling services.

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

Reason(s) for this authorization (check all that apply):

☐ at my request for my child's treatment
☐ other (specify) _____

This authorization ends:

☐ one year from the date signed below, **or** on _____(staff to fill in date)
☐ when the following event occurs: _____
(date)

II. ***My Rights***

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. Two ways to revoke this authorization are; 1) Fill out a revocation form. A form is available at the reception desk at Boyer or 2) write a letter to Boyer Children's Clinic. If I did, it would not affect any actions already taken by Boyer Children's Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

Last Update: April 2017