Children's Center

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____ Date of Birth _____

Previous Name _____ Social Security # _____

I request and authorize Children's Center to release and exchange healthcare information for the patient named above to:

Name _____

Address _____

City, State, Zip _____

Email _____

Phone _____ Fax _____

This request and authorization applies to:

_____ Initial	Healthcare information relating to the following treatment, condition or dates:	
_____ Initial	☐ Yes ☐ No	All healthcare information
_____ Initial	☐ Yes ☐ No	Send Final Report
_____ Initial	☐ Yes ☐ No	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
_____ Initial	☐ Yes ☐ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

_____

Signature of Legal Guardian | Printed Name of Legal Guardian | Date | Relationship to Patient

_____

Witness | Date

OFFICE USE ONLY: Approved to send without Witness:	_____ Initial

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER DATE OF SIGNATURE.

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