1911 Cooks Hill Rd
Centralia, WA 98531

Northwest Pediatric Center

Phone: 360-736-6778
Fax: 360-736-6552
www.nwpeds.com

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ DOB: ____/____/_____

Release: ☐ From ☐ To	**Release: ☐ From ☐ To**
Northwest Pediatric Center 1911 Cooks Hill Rd Centralia, WA 98531 Phone: 360-736-6778 Fax: 360-736-6552	Organization/Facility/Person: _____ Address: _____ Phone: _____ Fax: _____

☐ **Mutual Exchange** – Authorization for the Mutual Exchange of Information between the parties listed above whether orally, written, or electronically.

Information Relevant to this Authorization

☐ Last 3 years of Medical Records ☐ Medical Records from _____ to _____

☐ Chart Notes ☐ Hospital Records ☐ Medication List/Management

☐ Lab/Imaging Results ☐ Contact with School ☐ Itemized Billing Statements

☐ Other: _____

Specific Authorizations

Mental Health – Initial _____

I understand that my records may contain information regarding testing, diagnosis or treatment for mental health diagnoses. I give my specific authorization for these records to be released.

MINORS, 13 YEARS OF AGE AND OLDER MUST INITIAL

Drug/Alcohol – Initial _____

I understand that my records may contain information regarding diagnoses or treatment for drug or alcohol abuse. I give my specific authorization for these records to be release.

MINORS, 13 YEARS OF AGE AND OLDER MUST INITIAL

AIDS/HIV/STD – Initial _____

I understand that my records may contain information regarding testing, diagnosis or treatment of HIV/AIDS or sexually transmitted diseases. I give my specific authorization for these records to be released.

MINORS, 14 YEARS OF AGE AND OLDER MUST INITIAL

Purpose of Release

☐ Transferring Care ☐ Personal Use ☐ Attorney/Legal ☐ Coordination of Care ☐ Insurance

☐ Other: _____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. Treatment, payment, enrollment, or eligibility for benefits is not conditional on my agreement to sign this authorization.
- I can cancel this authorization at any time in writing to the NWPC Medical Records Department, except to the extent that action has already been taken, in which the information cannot be recalled.
- Any information used or disclosed as described by this authorization may no longer be protected by federal law and could be used or redisclosed by the receiving party.
- Unless revoked earlier by me, this authorization will remain in effect for 364 days after the date signed below.
- In accordance to state law, Northwest Pediatric Center has the right to charge for copying medical records. The fees set by Washington State are $1.24 per page for pages 0-30, and $0.94 per page for pages 31+.

_____ Parent/Guardian Name (Print)	_____ Patient Name (Print)
_____ Parent/Guardian Signature	_____ Patient Signature
_____ Date	_____ Date