Request For Medical Records

Patient name: ____ Date of birth: ______________________

Parent/Legal Guardian: __________________________________ Home Phone Number: ______________________

Release Records From: ____

Address: ____

City/State/Zip: ____

Phone: ____________________ **Fax:** ________________

Send Records To:

Northwest Pediatric Center, Inc., PS
1911 Cooks Hill Road
Centralia, WA 98531
Phone: 360.736.6778 Fax: 360.736.6552

I. My Authorization

You may use or disclose the following healthcare information (check all that applies):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relation to the following treatment or condition: ________________
- ☐ Health care information in my medical record for the date(s): ________________________________
- ☐ Other (e.g., X-rays, bills), specify date(s): ____

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

- ☐ HIV (AIDS virus)
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health or Illness
- ☐ Drug and/or Alcohol Abuse
- ☐ Reproductive Care (minors only)

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older)

Reason(s) for this authorization (check all that apply): ☐ at my request ☐ other (specify) ____________________
☐ transferring care

This authorization ends: In 90 days from the date signed.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

- To receive research-related treatment in connection with research studies **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 at any time. If I do, it would not affect any actions taken by Northwest Pediatric Center, Inc., in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Write a letter to the clinic, Northwest Pediatric Center, Inc. P.S.

III. Protection after Disclosure. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

Northwest Pediatric Center will only keep records for six months. We will destroy any medical records that have been in our possession for more than six months without an office visit/treatment from one of our providers.

____ ______________________________

Patient or legally authorized individual signature | Date | Time

____ ______________________________

Printed name if signed on behalf of the patient | Relationship

____ ______________________________

Minor patient's signature, if applicable | Date | Time

Revised July 2014

Medical Records Release

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