Ballard Pediatric Clinic
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Authorization to Use or Disclose/Release/Obtain Protected Health Information

NOTE: IT CAN TAKE UP TO TWO WEEKS TO PROCESS A RECORDS TRANSFER

Patient Name: _____ Date of Birth: _____

I. My Authorization

You may use, disclose or release the following health care information (check all that apply):

- o **ALL** health care information in the patient's medical record
- o Health care information in my medical records relating to the following treatment or condition:

  _____
- o Health care information in my medical record for the date(s): _____
- o Other (e.g., X-Rays, bills), specify date(s): _____

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

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

❖ **Ballard Pediatric Clinic may DISCLOSE this health care information TO:**

Name, Facility, Organization, Physician (or name of parent if minor): _____

Preferred Method of delivery:

Mail: Address: _____ City: _____ State: _____ Zip:_____

Fax:_____ **Email(secure):**_____ **Pick Up**-Phone: _____

❖ **Ballard Pediatric Clinic may OBTAIN this health care information FROM:**

Name, Facility, Organization, Physician (or name of parent if minor): _____

Address: _____ City: _____ State: _____ Zip: _____

Fax: _____ Email: _____

Reason(s) for this authorization:

- o Transfer of care o Personal use o Mutual exchange of information

This authorization ends:

- o Never
- o On (date): _____ o when the following event occurs: _____
- o In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment).

II. My Rights

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

- To take part in a research study **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. If I did, it would not affect any actions already taken by Ballard Pediatric Clinic based upon this authorization. I may not be able to revoke this authorization it it's purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Ballard Pediatric Clinic, **or**
- Write a letter to Ballard Pediatric Clinic.

Once health care information is disclosed, the person or organization that receives it may be re-disclose it. Privacy laws may no longer protect it.

_____ _____

Signature of Patient, Parent or Legally Authorized Individual Date:

_____ _____

Printed Name if Signed on Behalf of the Patient Relationship (parent, legal guardian, personal representative)