

## **Ballard Pediatric Clinic**

7554 15<sup>th</sup> Ave. N.W. Seattle, WA 98117 Ph.)206-783-9300 F.)206-315-8848

Printed Name if Signed on Behalf of the Patient

## Authorization to Use or Disclose/Release/Obtain Protected Health Information

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

	'atient Name:		Date of Birth:			
I.	My Authorization					
	You may use, disclose or release the following health care information (check all that apply):					
	=	rmation in the patient's	•	,,		
		Health care information in my medical record for the date(s):				
	<ul> <li>Other (e.g., X-Rays,</li> </ul>	bills), specify date(s):				
	You may use or disclose health care information regarding testing, diagnosis and treatment for (must check all that					
	apply):		a Carrially the respectate of discard			
	o HIV (AIDS virus)	/	o Sexually transmitted diseas	es		
	<ul> <li>Psychiatric disorders</li> </ul>	s/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 deliv					
	Mail: Address:		City:	State: _	Zip:	
	Fax:	Email(secure):	Pick	<b>Up</b> -Phone:		
			f parent if minor):			
	Address.		City:	State	= . P	
	Fax:		Email:	State		
	Fax:	[	Email:	State		
	Fax:	zation:	Email:o Mutual exchange o			
	Fax:	zation:	Email:			
	Fax:  Reason(s) for this authori   Transfer of care	zation:	Email:			
	Fax:	zation: o Personal use	Email:	of information		
	Fax:	zation: o Personal use o when t	Email:o Mutual exchange o	of information		
II.	Reason(s) for this authori  Transfer of care  This authorization ends:  Never  On (date):  In 90 days from the	zation: o Personal use o when t	o Mutual exchange of the following event occurs:	of information		
II.	Reason(s) for this authori  Transfer of care  This authorization ends:  Never  On (date):  In 90 days from the	zation: o Personal use o when tidate signed (if disclosure is	o Mutual exchange of Mutual exchange of Mutual exchange of the following event occurs:s to a financial institution or an employ get health care benefits (treatment, page the following the following exchange).	of information	ourposes other than payment).	
11.	Reason(s) for this authori  Transfer of care  This authorization ends:  Never  On (date):  In 90 days from the  My Rights  Understand I do not have to sign to authorization form:  To take part in a researce	zation: o Personal use o when to date signed (if disclosure is this authorization in order to get the study or	o Mutual exchange of the following event occurs:s to a financial institution or an employ	of information  er of the patient for particular properties or enrollment	ourposes other than payment).	
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Relationship (parent, legal guardian, personal representative)