Request for Primary Care Records

Patient name: _____ Date of birth:_____

Parents' names: _____

The Child and Adolescent Clinic may:
OBTAIN my healthcare information from:

Name or Organization:_____

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

Phone:_____ Fax:_____

I. I request and authorize the release of the following information to The Child and Adolescent Clinic. Please fax records to 360-423-9537

☒ Most recent Well Child chart note, Growth Chart, Immunizations, Medication List

☐ Other Records: _____

II. This authorization ends: *(This document does not permit disclosure of health information more than 90 days or 1 year after the date it is signed.)*

☐ 90 days from the date signed below
☒ 1 year from the date signed below

Clinician Name:

Child and Adolescent Clinic
971 11th Avenue
Longview, WA 98632

Phone – 360-577-1771
Fax – 360-423-9537

I authorize the transfer of my health care information to Child and Adolescent Clinic.

_____ _____
Patient's signature if 16 years or older **Date**

_____
Parent or legal guardian signature if patient is less than 16 years of age

Relationship to patient (parent or legal guardian)

_____

Faxed date: _____ Faxed by: _____