Intergalactic Pediatrics

3316 NE 125th St Suite, Seattle WA 98125 – phone 206-203-2509 – fax 855-897-3364

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize:

□ Treehouse Family Medicine PLLC dba Intergalactic Pediatrics

□ Facility/Providers Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #:_____ Fax #: _____

To release:

□ Complete Chart (doesn't include billing information or other providers records unless specified below)

□ Chart Notes: □ All □ Specify _____

□ Labs and imaging: □ All □ Specify _____

□ Billing Records: □ All □ Specify _____

□ Other: _____

The health records of:

Name: _____ Date of Birth: _____ Phone # : _____

Are you authorizing release of your own records? □ YES □ NO If not, what is your relationship to the patient? _____

Release of certain medical information requires a minor's consent. This includes information pertaining to substance abuse, mental health information, sexually transmitted diseases, HIV and AIDS.

To be released to:

□ Facility/Providers Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #:_____ Fax #: _____

□ Myself. Provide current address below. Fees apply as follows: $25 for < 100 pages, $50 for 100+ pages.

Address: _____

City: _____ State: _____ Zip: _____

□ Intergalactic Pediatrics

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For the purpose of:

□ Concurrent care □ Transfer of care □ Other (specify) _____

I understand that unless revoked this authorization is valid for 90 days form the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to the following unless you check the boxes below to **EXCLUDE** release of information related to:

□ **Substance abuse** □ **Mental Health conditions/psychotherapy** □ **Sexually transmitted diseases and** □ **HIV / AIDS**

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would be no longer protected. I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call 206-203-2509 to inquire about revoking authorization. I understand that if I request records for personal use, to hand carry to another healthcare provider or for parties not involved in my health care, there may be a charge. Non-emergency release of records may take up to 15 working days. Emergency requests will be given priority. Emergency status applies only to release of records directly to another healthcare provider for urgent patient care.

Patient's signature: _____ Date: _____

Representative/guardian's signature: _____ Date: _____