evergreen pediatric clinic

505 NE 87th Ave Suite 120
Vancouver, WA 98664
PH.360-892-1635
FAX.360-892-3146

Patient Name: _____ Date of Birth: _____/_____/_____
Please print full name.

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____
Release Purpose: ( ) Self ( ) Changing provider ( ) Consultation ( ) Legal ( ) Other: _____
(If you are receiving records for yourself, there will be a charge of $.50 per page up to $25.00, that will be due at the time of pick up)

I authorize **Evergreen Pediatric Clinic** to (check all appropriate boxes, and provide complete name and address information):

☐Give records to: ☐Verbally exchange with: ☐Request records from:

Name: _____ Phone: _____ Fax: _____

Address: _____
Street City State Zip Code

Email: _____

Evergreen Pediatric Clinic accepts medical records via PAPER or CD.

By initialing spaces below, I specifically authorize the release of the following medical records if such records exist:

_____ Chart notes _____ Laboratory reports _____ ALL medical records
_____ Diagnostic imaging _____ Immunization records _____ ☐Past 2 years
_____ Other: _____

SENSITIVE RECORDS MAY REQUIRE PATIENT AUTHORIZATION; Please initial all spaces of records you want to obtain/send.

Records containing the following information require consent from the minor (items must be initialed to be released):

_____ Mental health treatment/ADHD&ADD/Behavioral Health (13 and older)
_____ Reproductive health care (all ages)
_____ Drug/alcohol abuse/diagnosis & treatment (13 and older)
_____ STD/HIV/AIDS (14 and older)

Under Washington state law, minors may have the right to consent to certain types of care at certain ages, without parental consent, and in those cases, generally only the minor may authorize the use and disclosure of the related medical records information. Consult legal counsel to learn when a minor's authorizations may be needed and incorporated those requirements into your organization authorization form.

- I understand I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form 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 Evergreen Pediatric Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form or I may write a letter to Evergreen Pediatric Clinic.
- Once health information is disclosed, the organization the received it may re-disclose it. Privacy laws may no longer protect it
- ***THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE OF SIGNATURE***

X_____ _____ X_____/_____/_____
Signature of Patient/Parent/Legal Guardian Print Name | Relationship to Patient Date

X_____ _____ X_____/_____/_____
SIGNATURE REQUIRED when releasing sensitive records Print Name Date