AUTHORIZATION TO RELEASE/OBTAIN/EXCHANGE PATIENT HEALTH INFORMATION

Patient *

Patient Name: _____ (Last / First / Middle) Date of Birth: ____/____/____ (Month / Day / Year)

Other Names Used: _____ (if applicable) Medical Record Number: _____ (if known)

Release

I authorize Seattle Children's Hospital to: ☑ Release To ☑ Obtain From ☑ Exchange With (Verbal Information Only)

Organization/Recipient: Northwest School for Deaf & Hard-of-Hearing Children Attn: Administrator

Address: 15303 Westminster Way N City: Shoreline State: WA Zip Code: 98133

Phone #:(206) 364-4605 Fax #:(206) 367-3014 Email: a.castaneda@northwestschool.com (required for CD and electronic delivery)

Delivery/Purpose

Paper copies will be mailed to the recipient unless another format is checked below:

☐ CD (compact disc) ☑ Secure Electronic Delivery (patient/family only) ☐ Pick-up (we will call you when records are ready)

Please indicate the purpose(s) of your request:

☐ Continuing Care ☐ Transfer of Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Disability ☑ School

☐ Other (please specify): _____

Information

Records for Dates:

From 1/1/2019 (Month/Year) -- To ongoing (Month/Year)

If no date is specified, an abstract of records will be released (most recent clinical documentation)

☐ Inpatient Hospital Stay
☑ Outpatient Clinic/Emergency Department
☐ Lab & Radiology Reports
☐ Operative/Procedure Notes
☐ Radiology Images (on CD)
☐ Billing Records

☐ PBMU Summary/Care Plan
☑ Educational Services Summary
☑ Other (please specify)
Audiograms, Audiology, Speech-Language Clinic Notes

Notices

I understand that:

- Signing this release of health information is voluntary; I do not need to sign this form for treatment or payment.
- Any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- I can cancel this authorization at any time, by informing the Health Information Management department in writing. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

Signatures

This authorization expires **one year** from the date signed **unless** another date or event is indicated here: 12/31/2025

Exception: if patient information is to be released to an employer or financial institution, this authorization is only valid for 90 days from the date signed.

Minors (age 13-17) - A minor patient's signature is required below to release the following information: 1) conditions related to reproductive care including, but not limited to, birth control, pregnancy-related services and sexually transmitted infections including HIV/AIDS (age 14 or older) 2) mental health conditions (age 13 and older) 3) drug and alcohol abuse diagnosis or treatment (age 13 and older) (This information is subject to Federal Regulation 42 CFR Part 2 - See reverse for more information).

I specifically authorize Seattle Children's to release health information checked below:

☐ Reproductive Care ☐ Sexually Transmitted Infections (incl. HIV/AIDS) ☐ Mental Health ☐ Drug/Alcohol Abuse

_____ Signature of Minor Patient _____ Printed Name _____ Date Signed

_____ Signature of Patient/Legal Representative (parent) _____ Printed Name _____ Relationship to Patient *

(_____) _____ Phone Number _____ Date Signed

Staff

Have the records been released to the requestor? ❑ YES ❑ NO Staff Name: _____ Clinic/Unit _____

Please forward the completed authorization to the Health Information Management department (M/S S-216)

Seattle Children's®
HOSPITAL · RESEARCH · FOUNDATION

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PHONE: 206-987-2173 FAX: 206-985-3252

44036

PATIENT LABEL