Medical Records Release Form

Please Download, Print, & Bring Filled out to your first appointment.

If you are unable to bring the New Patient Paperwork with you, arrive 10 minutes prior to your appointment.

Thank You!

AUTHORIZATION FOR RELEASE OF INFORMATION

Patients Name: _____ DOB: _____

Information to be released from:	Information to be released to:
Organization: _____	Name: **Chehalis Children's Clinic**
Address: _____	Address: **370 S Market Blvd**
_____	**Chehalis, WA 98532**
Phone: _____	Phone: **(360) 748-6693**
	Fax: **(360) 748-3619**

Purpose of Disclosure: ___Continuing Care ___Legal ____Insurance ____At Patient Request for Patient use
___ Other (explain) _____

All health information_____ Labs/X-rays, Specify Dates_____
___Healthcare information for the following treatment or condition_____
___Healthcare information for the dates(s):_____

_____ _____ _____
Date Signature of patient or patient's authorization representative Relationship to patient if not a patient

RELEASE REQUIRING SPECIFIC CONSENT:

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for:

____ HIV/AIDS
____ Sexually Transmitted Diseases
____ Reproductive Care (minors only)
____ Mental Health
____ Alcohol/Drug Abuse

MINORS -A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, and sexually transmitted diseases (age 14 and older). (2) alcohol and/or drug use(age 13 and older), and (3) mental health conditions (age 13 and older).

_____ _____ _____
Date Signature of patient or patient's authorized representative Relationship to patient if not patient

_____ CHECK IF PATIENT IS A MINOR

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that the person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

This authorization expires_____(date). Authorization will expire in ninety days if not otherwise specified.

For medical records over 10 pages please fax to 844-660-4036