

AUTHORIZATION TO OBTAIN/RELEASE PATIENT HEALTH INFORMATION

PATIENT NAME: _____
 DATE OF BIRTH: _____
 SEATTLE CHILDREN'S MED REC # _____

DEPARTMENT OF: PSYCHIATRY AND BEHAVIORAL MEDICINE
 SOCIAL WORK
 DIVISION OF: PEDIATRIC NEUROLOGY
 REHABILITATION PSYCHOLOGY
 ADOLESCENT MEDICINE

I authorize Seattle Children's Hospital to (check all that apply) Obtain information Release information Mutual exchange of information

Organization/Individual: _____ Attn: _____

Address _____

City, State, Zip _____

Phone #: (____) _____ Fax#: (____) _____

Information to be Obtained:

- Dates of service for records requested: from _____ to _____
- OT/PT/Speech reports
 - Child welfare/CPS records
 - Juvenile court/probation records
 - Chemical dependency records
 - Psychosocial assessment
 - Neuropsychological evaluation
 - Developmental Evaluation
 - Verbal exchange of information
 - Other _____
 - Outpatient psychiatric evaluation
 - Psychological testing/assessment (including subtests scores)
 - Inpatient psychiatric discharge summary
 - Psychological/Psycho-educational Assessment records
 - Psychotherapy records/treatment plan
 - Outpatient medical notes
 - Birth/neonatal records
 - Growth charts
 - Laboratory/test reports
 - Education records
 - Individualized Education Plan
 - Inpatient medical notes
 - Psychiatric treatment/crisis plan

Information to be Released:

- Dates of service for records requested: from _____ to _____
- Discharge summary
 - Outpatient psychiatric evaluation
 - Psychological testing/assessment
 - Psychiatric treatment/crisis plan
 - Psychiatric treatment/termination summary
 - Inpatient psychiatric discharge summary
 - Psychological/Psychoeducational Assessment records (including subtest scores)
 - Psychotherapy records/treatment plan
 - Written and/or phone confirmation of outpatient psychiatry appointments sent to patients residence
 - Other _____
 - Inpatient Psychiatry Education Dept Discharge Summary
 - Developmental Evaluation
 - Psychosocial assessment
 - Neuropsychological evaluation
 - Inpatient medical notes
 - Medication management notes
 - OT/PT/Speech records
 - Verbal exchange of information
 - Chemical dependency records

For the Purpose of:

- Participation in outpatient inpatient medical psychiatric neuropsychological developmental evaluation/treatment
- Coordination of care between multiple providers
- Transfer of care to a new provider
- Other (please specify): _____

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
 - I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
 - Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire one year from the date signed below unless another date or event is entered here _____
- Exception: If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days from date signed.
- I specifically authorize Seattle Children's Hospital to release health information regarding mental health/illness and alcohol/drug abuse.

Signature of patient (13+ years) _____ Date signed _____

Signature of parent/legal representative _____ Relationship to patient _____ Date signed _____

Release Requiring Specific Consent- I specifically authorize Seattle Children's Hospital to release health information checked below:

- Sexually Transmitted Diseases (incl. HIV/AIDS) Reproductive Care

Signature of Patient/Legal Representative _____ Printed Name _____ Date _____

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

Requested Records to be Sent to:

- Seattle Children's Division of Psychiatry, PO Box 5371, W3636, Seattle, WA 98105-0371, Fax: (206) 987-2246
- Seattle Children's Inpatient Psychiatric Unit, PO Box 5371, T-2210, Seattle, WA 98105-0371, Fax: (206) 987-5097
- Seattle Children's Inpatient Psychiatric Unit Intake Coordinator Fax: (206) 987-5011
- Seattle Children's Social Work Department, PO Box 5371, W3638, Seattle, WA, 98105-0371, Fax (206) 987-2246
- Seattle Children's Bellevue Behavioral Health, 1135 116th Ave. N.E., Suite 400, Bellevue, WA 98004, Fax: (425) 637-5945
- Seattle Children's Neurology Neuropsych B-5552, PO Box 5371, Seattle, WA 98105-0371; Fax: (206) 987-2649; Dr. Shurtleff Dr. Warner
- Seattle Children's Rehabilitation Psych W-6839, PO Box 5371, Seattle, WA 98105-0371; Fax: (206) 987-2409; Dr. _____
- Seattle Children's Adolescent Medicine W7831, PO Box 5371, Seattle, WA 98105-0371; Fax: (206) 987-3959; Dr. _____



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**PSYCHIATRIC/SOCIAL WORK/PEDIATRIC
 NEUROLOGY/REHABILITATION PSYCHOLOGY ADOLESCENT MEDICINE
 AUTHORIZATION TO OBTAIN/RELEASE PATIENT HEALTH INFORMATION**

PATIENT LABEL

DRUG AND ALCOHOL ABUSE INFORMATION

Federal regulations (42 CFR part 2) prohibit any further disclosure of this information except with written consent of the person to whom the information pertains or the parent or legal guardian of the minor child to whom it pertains, unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

MENTAL HEALTH INFORMATION

State law (RCW 71.05.39) prohibits any further disclosure of mental health information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose.

CONSENT FOR MINOR

A minor patient's signature is required in order to release information concerning care for: (1) birth control and pregnancy related care if the minor is 14 or older (2) sexually transmitted disease information (including AIDS/HIV) if the minor is 14 or older (3) substance abuse diagnosis or treatment if the minor is 13 or older (4) mental health information if the minor is 13 or older.

FEE FOR COPYING MEDICAL RECORDS

There may be a fee for copying the medical records. Please ask the Release of Information personnel for information about the fee schedule. There will be a charge for copying the entire record.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal and state laws prohibit redisclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



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