

Cascade Pediatrics
22526 SE 64th Pl, Ste 120
Issaquah, WA 98027
(425)369-0808
Fax (425)369-0770

Authorization for Release of Medical Records

-----Patient Information-----

Patient's Name: _____

Address: _____

Phone: _____ Date of Birth: _____

I hereby authorize: _____

To release the following information pertaining to my medical care: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Labs/x-rays |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Immunization Record | |

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. You are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.

This information is to be **disclosed** to : _____

For the purpose of : Moving Insurance Change Appt w/specialist other

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

Signed: _____ Date: _____
(patient)

Or (Legal representative) (relation to patient) Date: _____

Charge for Copies:

Requests for copies of CURRENT MEDICAL RECORDS (PREVIOUS TWO YEARS) generated by Cascade Pediatrics, PLLC to be sent to another physician will be PROVIDED AT NO CHARGE.

Copies of COMPLETE MEDICAL RECORDS for personal use or to be sent to another physician will be provided at a rate of \$15.00 per record. Payment for this charge must be received prior to records being released.

Thank you.

Office Staff Only:

Paid _____ Pay when P/U _____ Initials _____