2475 140th Ave. NE, Building C
Bellevue, WA 98005
Fax: (425) 460-3374

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

The fee for providing a copy of your medical record release is $1.17 per page for the first 30 pages, plus .88¢ per page thereafter.

Patient Name _____ Date of Birth ____/____/____

Contact Numbers ( ) _____ ( ) _____

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
❑Allegro Pediatrics or ❑ _____ Organization / Person _____ Street Address City, State, Zip _____ Phone Fax#	❑Allegro Pediatrics or ❑ _____ Organization / Person _____ Street Address City, State, Zip _____ Phone Fax#
❑I authorize ongoing communication between the parties above.	

INFORMATION TO BE RELEASED

❑ AP Health Records ❑ Entire Record ❑AP Billing Record

❑ Other (please specify) _____

Format for records (please check ONLY one box): ❑Paper ❑CD

Please note if format is not selected, records will be in CD format.

PURPOSE OF RELEASE

❑Legal ❑Personal use ❑Continuing Care ❑Transfer to another provider ❑ School

❑Other _____ ❑ Reason _____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare 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 written notification to Allegro Pediatrics. 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 releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90 days from the date signed below unless another date or event is entered here _____ (Note: If the disclosure is to another employer or financial institution, this authorization will expire 90 days from the date signed by you.)

Sensitive Records may require specific patient authorization, please check the applicable box below to request the following records:

❑Drug/Alcohol abuse/treatment & diagnosis ❑Sexually transmitted diseases ❑Mental Health Treatment

❑HIV/AIDS diagnosis/treatment/testing ❑Reproductive Health Care

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services (all ages) 2) Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 3) Substance abuse and mental health treatment (age 13 and older).

_____

Signature of Minor Patient Date

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

_____

Signature of Patient or Legally Responsible Party Date

Relationship to patient, if not signed by patient