Business Office
2475 140th Ave. NE, Building C
Bellevue, WA 98005
Fax: (425) 460-5606

AUTHORIZATION AND REQUEST TO RELEASE PATIENT HEALTH INFORMATION TO MOTOR VEHICLE INSURANCE

Purpose for Release:

By completing this form I authorize and request that **Allegro Pediatrics** release medical and billing records for treatment received relating to the **Date of Accident**: ____/____/_____

Motor Vehicle Insurance Carrier/Organization **Claim Number**

Insurance Claims Mailing Address **City, State, Zip**

Medical Claims Adjuster **Phone Number**

AUTHORIZATION FOR 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.
- 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.

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS:
A minor patient's signature is required to release the following information: 1) Information related 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)

This form must be signed by a parent or guardian if the patient is under the age of 18. This authorization will expire **two years** from the date signed below unless another date or event is entered here:

_____

Patient Name: _____ Date of Birth: ____/____/_____

Signature of patient or parent/guardian if patient is under 18

Printed name Date Relationship