



# Kitsap Children's Clinic, LLP

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## AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS TO ANOTHER LOCATION

I \_\_\_\_\_ authorize Kitsap Children's Clinic, LLP to send the following personal information (please provide a description of the information)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

To. \_\_\_\_\_ at the following address: \_\_\_\_\_

Phone: \_\_\_\_\_

This authorization will remain effective until: (Please write a specific date or specify an event) \_\_\_\_\_

(In no event will an authorization remain valid for more than 24 months. WAC 284-04-515(e)(2).

Personal information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinician office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I understand that if Kitsap Children's Clinic needs my specific authorization to release information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

**Chemical Dependency**

(includes alcohol/drug treatment) \_\_\_\_\_ (Initials)

**HIV/AIDS & STDs**

\_\_\_\_\_ (Initials)

**Mental health information**

(Including psychotherapy notes) \_\_\_\_\_ (Initials)

**Reproductive Health Care Decisions**

(Abortion, birth control, pregnancy, etc) \_\_\_\_\_ (Initials)

I understand that I may cancel this authorization at anytime submitting a Revocation of Authorization form. My cancellation of this authorization will not affect any action Kitsap Children's Clinic, LLP took before it received my request. I understand that this authorization is valid for a period no greater than 90 days.

I understand that if Kitsap Children's Clinic, LLP discloses my personal information at my request, and the party receiving this information shares it with others, some state and federal laws may no longer protect it.

***If patient is 14 years of age or older, patient MUST sign for records transfer.***

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Personal representative's name: \_\_\_\_\_

Relationship to patient:  Parent  Legal guardian\*  Holder of Power of Attorney\*  Other

**\*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.**

ALL FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID

**A copy of this form is to be kept by: a) the individual signing the form, b) Kitsap Children's Clinic, LLP c) and a third copy should accompany any disclosed personal information.**