THE POLYCLINIC PEDIATRICS AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FOR VACCINE HISTORY AND SPORTS PHYSICALS ONLY

Patient Name | Last | First | Middle | Maiden

Address | Street | Apt. # | City | State | Zip

Phone ( ) Date of Birth / /

Polyclinic Physician's Name:

I AM REQUESTING THIS INFORMATION BECAUSE:

☐ Personal Use* ☐ Legal Use** ☐ School Admission
☐ Seasonal Sports ☐ Day Care ☐ Other Reason:

NOTE: A charge may be incurred for copies being provided for legal, insurance, personal use and, in some instances, the "other" category

Once Protected Health Information is released by The Polyclinic, it can not be guaranteed that the recipient will not disclose the information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of health information. I understand that I do not have to sign this form to receive health care benefits.

Please Check One

☐ Vaccine History

☐ Physical Forms

☐ Other (please specify):

Please Check One (If no box is checked, "sensitive" information will not be released.)

Your facility ☐ ***is*** / ☐ ***is not*** authorized to release any health care information relating to such diagnosis, testing, or treatment relating to the: **testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders / mental health, or treatment of drug and/or alcohol abuse**.

NOTE: In compliance with Washington state law, minors must sign the request themselves if information requested includes: a) treatment for alcohol and/or drug abuse (13 and older), b) mental health conditions or c) conditions related to the minor's reproductive care and sexual history to include contraception, pregnancy, pregnancy termination, sterilization and STDs (age 14 or older).

Please check one and complete the appropriate information:

☐ I request and authorize The Polyclinic **to release** health information to:

Physician / Clinic Name:
Address:
City, State:
Zip Code:

I release The Polyclinic and its staff from all legal responsibility or liability that may arise from the release of information. I understand that I may revoke this consent in writing at any time, except when action has already been taken.

Signature of Patient Date

Relationship or Status if signed by anyone other than Patient (i.e. Parent, Legal Guardian, Personal Representative, etc.) Date

THIS AUTHORIZATION EXPIRES IN ONE YEAR OR UNTILTHE FOLLOWING EVENT OCCURS: ____

MAIL REQUESTS TO:
THE POLYCLINIC
ATTN: PEDIATRICS
904 7th AVE, 3rd FLOOR
SEATTLE, WA 98104

FAX REQUESTS TO: 206-292-2018
FOR QUESTIONS PLEASE CALL: 206-292-2249

Copy Fees:
Patient
Less than 10 pages or last 2 years are free.
$0.42 / page or $20 (whichever is less) for over 2 yrs.

Third-Party Vendors (PRE-PAY ONLY)
$21 clerical fee, $1.02/pg < 30 and $0.78/pg 30+

THE POLYCLINIC