

RELEASE OF MEDICAL RECORDS:

In accordance with state law and regulatory agency requirements I hereby authorize your facility to release medical records to, C & C Medical Associates Pediatric Clinic, Federal Way, WA. for the child/children listed below.

Patient Name (1) _____ Date of Birth _____

Patient Name (2) _____ Date of Birth _____

Address _____ Home# _____

City _____ State _____ Zip _____

Cell# _____

Information May be Released TO:

Name: C & C Medical Associates Pediatric Clinic

Address: 118 SW 330th Street, Ste 300

City/State/Zip: Federal Way, WA 98023

Tel: 253-878-5193

Fax: 253-242-7169

From:

Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Fax#: _____

Please Release the Following Information:

Complete Record X-ray Reports Mental Health Progress Notes Problem List X-ray

Films Lab Reports History & Physical Exam Immunizations EKG Reports HIV/AIDS

Test Medications

Other, Specify _____

This information is necessary for the following Purpose (s):

Insurance Personal Use Attorney/Legal Continued Care

Other, Specify _____

1. I understand that the information in my health record may include information relating to sexually transmitted diseases(s), Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to C & C Medical Associates Pediatric Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration, event, or condition, this authorization will expire in six months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact C & C Medical Associates Pediatric Clinic at 253-878-5193.

I understand that C & C Medical Associates Pediatric Clinic may receive direct or indirect remuneration as a result of disclosing this information due to:

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness