Pediatric Associates of Whidbey Island
Release of Information

PATIENT NAME: _____
DOB: _____

☐OBTAIN my healthcare information from:☐SEND my healthcare information to:

Name or organization: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: _____ Fax: _____

Reason for records request (check one):
☐ Switching practices and reason for switching: _____
☐ Other reason: _____

☐ **Basic records request (no additional fee) Includes:**
- ✓Summary of Care
- ✓Most recent well visit
- ✓growth charts,
- ✓immunization records,
- ✓recent lab/radiology (if applicable) ***This packet will be uploaded to your patient portal*

☐ All health care information
☐ Communication regarding behavior and learning: _____
☐ All psychiatric and mental health information, plus drug and alcohol use information
☐ All health care information regarding testing, diagnosis, and treatment for (check all that apply):
□ HIV (AIDS virus) □ Sexually transmitted disease

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by *Pediatric Associates of Whidbey Island* based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from *Pediatric Associates of Whidbey Island* or
- Write a letter to *Pediatric Associates of Whidbey Island.*

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

III. This authorization ends: *(This document does not permit disclosure of health information created more than 365 days after the date it is signed.)*

This authorization expires in one (1) year from the date signed unless another date or event is indicated here:

Pediatric Associates of Whidbey Island Ph: (360) 675-5555
275 SE Cabot DR #B-102 Fax: (360) 675-0275
Oak Harbor, WA 98277

*I authorize the transfer of my health care information **to or from** the above address or to my patient portal. PAWI does not charge for the basic records request and for records that are uploaded to your patient portal. Other requests may incur a $25.00 process fee, plus $1.12 per page for the first 30 pages, and $0.84 per page after 30 pages, plus sales tax. Payment is due when records are picked up.*

_____ Date: _____
Patient's signature if 16 years or older (13 years for mental health)

_____ _____
Parent or legal guardian signature if patient is less than 16 years of age **Name of Legal Guardian**
PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING