



## RELEASE OF MEDICAL RECORDS:

In accordance with the WA state law and regulatory agency requirements I hereby authorize your facility to release medical records for the child/children listed below.

Patient Name (1) _____ Date of Birth _____

Patient Name (2)_____ Date of Birth _____

Patient Name (2)_____ Date of Birth _____

Address_____ Home# _____

City_____ State_____ Zip_____

Cell#_____

**FROM:**

Name:_____

Address:_____

City/State/Zip:_____

Phone #: _____

Fax#: _____

## TO mail or fax

## Please use our clinic locations

Bellevue Pediatrics
C & C Medical Associates
1940 116th Ave NE, STE 200
Bellevue, WA 98004
Tel: 425-209-4331
Fax: 206-899-1299

Federal Way Pediatrics
C & C Medical Associates
710 S 348th St. STE B
Federal Way, WA 98003
Tel: 253-878-5193
Fax: 253-242-7169

Main Line: 425-298-6679

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 any time. 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 disclosure 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 Clinics at 425-298-6679.

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 Legal Representative/Guardian Date

_____ _____

Signature of Patient Date
(Signature for Patient >15 years old is required)

_____ _____

Relationship to Patient Witness