AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name_____ Acct#_____
Former Name (if any) _____ SS # _____
Daytime Telephone _____ Birthdate _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize _____
to release the following medical information contained in the patient's records.
Address: _____
Street City State Zip

INFORMATION TO BE RELEASED TO:

_____
Name of organization

_____
Street City State Zip
Purpose or need for this information is: _____

TYPE OF INFORMATION TO BE RELEASED

1. GENERAL RELEASE

Type of Record

_____ Medical records/excluding protected records From _____to_____
(this will be limited to 2 yrs of information
including x-ray, Lab reports unless otherwise stated)
_____ Lab Results (specify) From _____to_____
_____ X-ray Reports (specify) From _____to_____
_____ Surgical Records (specify) From _____to_____
_____ Other Records (specify) From_____to_____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW

_____ Drug Abuse Diagnosis/Treatment* From_____to_____
_____ Alcoholism Diagnosis/Treatment* From_____to_____
_____ Mental Health Diagnosis/Treatment** From_____to_____
_____ Sexually Transmitted Disease From_____to_____
Diagnosis/Treatment or Couseling**
(includes AIDS/HIV)

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____
Date Signature of Patient
Legally Responsible Party

Authorization Valid for 90 days only and may be revoked in writing at any time prior to 90 days by notifying the records dept.
(To be valid Authorization must be signed and dated. See back for further information.)

*** DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION:**

Federal regulations (42CFR part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the patent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal law. A general authorization of the release of information is NOT sufficient for this purpose.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of the law shall be fined not more than $500.00 in the case of a first offense and not more that $5,000 in the case of each subsequent offense. (See 42 U.S.C., 290dd-3 and 42 U.S.C., 290cc-3)

** MENTAL ILLNESS INFORMATION

State law prohibits any further disclosure of mental illness information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains unless otherwise permitted by State Law,. A general authorization to release information is NOT sufficient for this purpose.
(SEE RCW 71.05.390 through RCW 71.05.410.)

***SEXUALLY TRANSMITTED DISEASE INFORMATION: (INCLUDES HIV/AIDS)

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose. Any violation of this law is a gross misdemeanor, and the law creates civil remedies for any violation which includes a $1,000 fine for a negligent violation, a $2,000 fine for an intentional or reckless violation of actual damages, whichever is greater, and attorney fees. (SEE RCW 70.24 and WAC 248-100.)

CONSENT OF MINOR (age 14 and above for Drug and Alcohol, and Sexually Transmitted Disease Information (including AIDS/HIVS); 13 and above for Mental Health Information)

Minor patients signature is required in order to release information concerning care for: 1., pregnancy termination and sexually transmitted diseases; 2. alcoholism or drug abuse; and 3. mental health conditions.

Kjartan D. Armann, M.D.
Infant, Child & Adolescent Medicine
340 Dardanelli Lane, Suite 25A
Los Gatos, CA 95032
(408) 374-5440
Fax (408) 374-5468

RECORDS RELEASE FORM

Please complete the attached Record Release Form and return it with *cash, money order or complete the credit card charge authorization section* (NO CHECKS WILL BE ACCEPTED) for payment in the amount $25 for each record requested. Upon receipt of this completed form and your $25 payment/payments, records will be copied and released as requested.

Thank you,
Kjartan D. Armann, M.D.

Credit Card Charge Authorization:

Type of Credit Card (**Visa, Mastercard, Discover)**

Name as Appears on Credit Card:

_____

Credit Card Number:

_____

3 Digit Security Code on back of card:

_____

Expiration Date (month and year):

_____

Zip Code: _____

Home Address:

_____

Authorized Signature:

_____