**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**RECORDS TO BE RELEASED FROM:**

Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby request and authorize you to furnish records at my request or for the purpose of:**

**Early Intervention Services**

**RECORDS TO BE SENT TO: Children FIRST – 2510 N Pines Rd Ste 3, Spokane Valley WA 99206**

**(509)315-5711 Fax (509)443-4170 ATTN: Diane Olney**

**Information to be disclosed:**

 **Immunization Records Diagnosis/tests Operative Reports Progress Notes**

 **Lab/Genetics Tests Written Records/Documents Mutual Communication**

PATIENT INFORMATION:

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it.
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations.
3. I am entitled to a copy of this document.
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment or eligibility for benefits.
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c)(4)(HIPPA).
6. This authorization shall expire upon my written request to revoke or on the patient’s 3rd birthday.
7. A copy of this authorization is as valid as the original.

I hereby authorize the Family Resource Coordinator of **Children FIRST** to share and discuss information regarding the child named on this release with those indicated in order to assist my family in accessing screenings, evaluations, funding and Direct Services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative’s relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by Permission to renew Date