Adolescent & Young Adult Medicine, P.S.

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AUTHORIZATION TO EXCHANGE HEALTHCARE INFORMATION

________________________________ *Patient Full Name*	________________________________ **Date of Birth and Social Security Number**
________________________________ **Patient Previous Name if applicable**	________________________________ **Date of Authorization**
	________________________________ **Day time phone**

I understand that my medical and mental health information and records are protected by Federal and State confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about a crime committed or suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical, bodily harm, or that anyone else is in danger of physical, bodily harm, that information is not protected under Federal regulations.

I understand that information about HIV/AIDS, sexually transmitted disease, mental health, and drug or alcohol treatment can be released only if I sign the special consent below.

I HEARBY REQUEST AND AUTHORIZE THE FOLLOWING EXCHANGE OF INFORMATION:

INFORMATION TO BE EXCHANGED BETWEEN	NAME:______________________________
Adolescent & Young Adult Medicine, P.S.	ORGANIZATION:______________________
P.O.Box 12257	ADDRESS:___________________________
Olympia, WA 98508	__________________________________
Phone: 425.646.0804 Fax: 206.202.1985	PHONE: ____________FAX:____________

PLEASE INDICATE TYPE OF INFORMATION TO BE EXCHANGE

GENERAL MEDICAL INFORMATION:

- ❑ Clinic Records: From________To______
- ❑ Lab Results: From________To________
- ❑ Radiology Reports/Films/Scans: From:_________To________
- ❑ Provider Letter: From______To_______
- ❑ Home Care: From_______To_______
- ❑ Hospital Records: From:______To______
- ❑ Psychotherapy/Counseling Records From_______To________
- ❑ Food Journals: From_______To_______
- ❑ Mood Journals: From_______To_______
- ❑ Other:________From:______To:_______

Date:_________Signature:_________________________________

Relationship To Patient:________________________

SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to testing, diagnosis and treatment for

- ❑ HIV/AIDS Virus
- ❑ Sexually Transmitted Diseases
- ❑ Mental Health/Psychiatric Disorders
- ❑ Drug, Alcohol Abuse/Treatment

Date:_______Signature:___________________________________

Relationship to Patient:___________________________________

CONSENT OF MINOR:

A minor's signature is required in order to release information concerning care for: (1) conditions relating to the minor's sexuality including, but not limited to, contraception, pregnancy and pregnancy termination and sexually transmitted diseases (age 14 and above), (2) alcoholism and/or drug abuse (age 13 and above), (3) mental health conditions (age 13 and above).

Date:__________Signature:________________________

There may be charges associated with your request. Identification may be required before releasing information. This authorization may be revoked in writing.