Mercer Island Pediatrics
18 Years of Age and Over
Patient Authorization Third Party/Parental Liability Form
To Use or Disclose Healthcare Information

Patient Name: _____ Date of Birth: _____

My Authorization
I voluntarily consent authorization to use or disclose the following healthcare information: (check all that apply)

- ☐ Medication refill requests
- ☐ Pick up prescriptions and/or completed forms
- ☐ Schedule an appointment and/or facilitate medical care
- ☐ Most recent physical exam, immunization, growth chart, summary of significant and/or chronic treatment.
- ☐ All healthcare information in my medical record -requesting printed records (charges may apply).
- ☐ All healthcare information in my medical record -requesting verbal communication only, no printed records.
- ☐ Only the following type of health information: _____

You may disclose healthcare information regarding testing, diagnosis, and treatment for (check all that apply)

- ☐ HIV (Aids Virus)
- ☐ Psychiatric Disorder/mental health
- ☐ Sexually transmitted diseases
- ☐ Alcohol and/or drug use

You may disclose this healthcare information to:

Name: _____ Relationship: _____

Address: _____ City: _____ ST: _____ Zip: _____

Today's Date: _____ **Signature Patient**: _____

This Authorization ends: (*This document does not permit disclosure of health information created more than 24 MONTHS after the date it is signed.*)

My Rights

I understand that I may revoke this authorization at any time by notifying Mercer Island Pediatrics in writing. If I choose to do so, my revocation will not affect any actions taken by Mercer Island Pediatrics before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

I understand that my health care provider cannot guarantee that the receipt will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

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Please fill out the contact information below for any further correspondence:

Patient's Name: _____ Phone: _____

Address: _____

Financial Responsibility Agreement and Assignment of Insurance Benefits

I hereby authorize my signature on all insurance claim forms at Mercer Island Pediatrics for payment directly to them for services rendered. I authorize Mercer Island Pediatrics to release any health care information necessary to my child by Mercer Island Pediatrics. I understand that I am responsible for charges incurred regardless of whether my insurance pays. I understand that the office policy requires payment in full when paying out of pocket at time of service unless other arrangements have been made. I understand and agree that any unpaid balance over 120 days may be assigned to a third-party collection's agency. I understand and agree to the above items.

- ☐ I intend to continue financial responsibility for the patient listed above.
- ☐ I do not intend to continue financial responsibility for the patient listed above.

Check only one:

- ☐ This consent is ongoing and shall remain in effect until revoked in writing by the undersigned.
- ☐ This consent shall remain in effect until the patient above reaches the age of _____.
- ☐ This is for services rendered on: _____.

Today's Date: _____

Printed Name Patient/Legal Guardian: _____

Signature Patient/Legal Guardian: _____