Authorization for Mercer Island Pediatrics
To Use or Disclose My Healthcare Information

Patient Name: _____ Date of Birth: _____

- ☐ **Release To**
- ☑ **Release From:** Mercer Island Pediatrics, 9675 SE 36th St, #100, Mercer Island
  Ph: 206-275-2122 FX: 206-275-0860

- ☑ **Disclose To**
- ☐ **Disclose From**
  Name of Other Provider_____
  Ph: _____ FX: _____

I. My Authorization

You may use or disclose the following healthcare information (check all that apply):

- ☐ All healthcare information in my medical record-**requesting printed records**
- ☐ All healthcare information in my medical record-**verbal communication only, no printed records requested**
- ☐ Healthcare information in my medical record relating to the following treatment or condition:
  _____
- ☐ Healthcare information in my medical record for the date(s) _____
- ☐ Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose healthcare information regarding testing, diagnosis, and treatment for:
(Check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☑ Psychiatric disorders/mental health
- ☑ Drug and/or alcohol use

Reason(s) for this authorization (check all that apply):

- ☑ At my request
- ☐ Other (specify) _____
- ☐ Check only if practice/facility requests the authorization for marketing purposes
- ☐ Check only if practice/facility will be paid or will get something of value for providing health information for marketing purposes

This Authorization ends: (*This document does not permit disclosure of health information created more than 90 days after the date it is signed.*)

- ☑ In 90 days from the date signed
- ☐ on (date): _____
- ☐ When the following event occurs: _____
  (no longer than 90 days from date signed)

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of patient Relationship (parent, legal guardian, etc.)