AUTHORIZATION TO EXCHANGE PATIENT HEALTH INFORMATION WITH SCHOOL

Patient Name: ______________________________

Seattle Children's Medical Record # (if known) ____________ **Date of Birth** ____/____/____

I authorize Seattle Children's Hospital to (check all that apply):

☐ **Obtain information from** ☐ **Release information to** ☐ **Oral exchange only**

School & Contact Person (if known):______________________ Attn:______________

Address ______________________________

City, State, Zip ______________________________

Phone # (____) ______________ Fax # (____) ______________

Information to be Released to School/Contact:

Dates of service for records release: from ______________ **to** ______________

☐ Outpatient Clinic Notes
☐ Discharge Summary
☐ School Care Plan
☐ Occupational Therapy Reports
☐ Speech and Language Reports
☐ Other: ______________
☐ Physical Therapy Reports
☐ Nutrition Reports

Information to be Obtained from School/Contact:

Dates of service for records requested: from ______________ **to** ______________

☐ Psychological Testing/Assessment
☐ Pupil Health Records
☐ Education Testing/Records
☐ Individual Education Plan (IEP) Special Services Record
☐ Early Intervention Services Plan
☐ Current/Past Medications
☐ Medical Treatment Records (including Clinic Notes)
☐ Physical/Occupational Therapy Reports
☐ Speech/Language Reports
☐ Audiology Reports
☐ Oral Exchange
☐ Other ______________

If obtaining records from a school, requested records to be sent to:

☐ Seattle Children's Hospital, Attn: ______________________ Mailstop ______________
P.O. Box 5371, Seattle, WA 98145, Phone ______________ Fax ______________

Seattle Children's: ☐ Bellevue Clinic ☐ North Clinic ☐ South Clinic ☐ Olympia Clinic ☐ Tri-Cities Clinic

☐ Bellevue at Overlake Medical Tower ☐ South Sound Cardiology ☐ Pediatric Cardiology of Alaska ☐ Pediatric Cardiology of Montana

☐ Other ______________ ☐ Odessa Brown ☐ Seattle Children's Home Care ☐ Wenatchee Clinic *See reverse side for clinic addresses*

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below unless another date or event is entered here ______________.
Exception: If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days from date signed.

______________________________ Signature of Patient/Legal Representative

______________________________ Printed Name

______________ Relationship to Patient

( ) ______________ Phone Number

______________ Date Signed

Release Requiring Specific Consent- I specifically authorize Children's to release health information checked below:

☐ Mental Health Records ☐ Alcohol/Drug Abuse ☐ Sexually Transmitted Diseases (incl. HIV/AIDS) ☐ Reproductive Care

______________ Signature of Patient/Legal Representative ______________ Printed Name ______________ Date

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

STAFF

Clinic/Unit:
For Obtain requests: mail or fax authorization, then place copy in chart. If chart is unavailable, send copy to HIM S-216.
For Release requests: Do you need HIM Department to send these records? Yes ☐ No ☐
If YES, send authorization to HIM S-216 If NO, place copy in chart, or send copy to HIM S-216.

Name: ______________ (Please Print) Clinic/Unit: ______________ Ext: ______________

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

Seattle Children's®
HOSPITAL · RESEARCH · FOUNDATION

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AUTHORIZATION TO EXCHANGE PATIENT HEALTH INFORMATION WITH SCHOOL

PATIENT LABEL

White - Chart Yellow - Legal Representative / Patient Pink - Organization / Individual

Guidelines for completing *Authorization to Exchange Patient Health Information with School* form

Purpose: To ask a school to share information about your child with a Children's health care provider, to have a Children's health care provider share information with someone at your child's school, or both.

Instructions to Staff:

- Check for completeness/legibility of key information:
  - Patient information
  - School contact's name and address
  - Clear indication of information being requested (both release and obtain portions, if appropriate)
  - Complete information about Children's recipient (clinic or provider)
  - Legal representative/patient's signature and contact information
- Complete the staff box, including your signature and department name and extension (to be contacted in case of a question)

What to do with the form:

- For Obtain requests: Mail or fax form to the school contact and
  - Place copy in chart, or
  - If chart unavailable, send to HIM S-216
- For release requests, clinic should provide information, if possible
  - Place copy in chart, or
  - If chart unavailable, send to HIM S-216
- If you need HIM to send these records, please send to HIM S-216 with "yes" box in staff section checked

Guidelines for Families:

Completing the form:

- Please make sure to complete all relevant sections of this form, including:
  - Patient information
  - Detailed name and address of school contact
  - Signature of legal representative/patient, and contact information

Where to take or send it:

- If you complete this form at Children's, give it to a clinic or inpatient unit staff member to send to the Health Information Management department
- If you are completing this form at home, mail or fax the completed form to the Seattle Children's Health Information department at: PO Box 5371 M/S S-216 Seattle, WA 98145

Where to call with questions:

- Complete this form in clinic with staff member assistance, or
- Call the Health Information Management department (206) 987-2173

Additional Information

CONSENT OF MINOR

A minor patient's signature is required in order to release the following Information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions, (age 13 and older).

FEE FOR COPYING MEDICAL RECORDS

There may be a fee for copying the medical records. Please ask the Release of Information personnel for information about the fee schedule. There will be a charge for copying the entire record.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal and state laws prohibit redisclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Clinic Addresses

Pediatric Cardiology of Alaska, 3841 Piper St. Suite T 345, Anchorage, AK 99508, 907-339-1945, Fax 907-339-1994
Pediatric Cardiology of Montana, 2510 Bobcat Way, Great Falls, MT 59405, 406-771-3223, Fax 406-452-5262
Seattle Children's Bellevue at Overlake Medical Tower, 1135 - 116th Ave NE, Suite 400, Bellevue, WA 98004, 425-454-4644, Fax 425-451-0214
Seattle Children's Bellevue Clinic, M/S CB-21, PO Box 5371, Seattle, WA 98145-5005, 425-454-4644, Fax 206-884-9363
Seattle Children's Home Care, 2525 220th St. SE, Suite 101, Bothell, WA 98021, 425-482-4000, Fax 206-985-3316
Seattle Children's North Clinic, 900 Pacific Ave, Suite 100, Everett, WA 98201, 425-304-6080, Fax 425-304-6085
Seattle Children's South Clinic, 34920 Enchanted Pkwy. S, Federal Way, WA 98003, 253-838-5878, Fax 253-838-1962
Seattle Children's Olympia Clinic, 615 Lilly Road NE, Suite 140, Olympia, WA 98506, 360-459-5009, Fax 360-459-8785
Seattle Children's Tri-Cities Clinic, 969 Stevens, Suite 1B, Richland, WA 99352, 509-946-0976, Fax 509-946-0983
Seattle Children's Wenatchee Clinic, 526 N. Chelan Ave, Suite B, Wenatchee, WA 98801, 509-662-9266, Fax 509-662-9284
South Sound Cardiology, 1901 South Cedar Street, Suite 103, Tacoma, WA 98405, 253-272-1812, Fax 253-682-1455