# Authorization to transfer care and release records

# from Integrative Pediatrics to NW Pediatrics Integrative Medicine

*Please use separate forms for each child*

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____)_____ Email:_____

_____

Street Address City State Zip Code

**I am transferring my primary care from Integrative Pediatrics to NW Pediatrics Integrative Medicine and I request the release of my complete medical record.**

**Protected & Sensitive Information**

I understand that my transferred medical records may contain sensitive information, which is protected by law, unless I decline to release the information as indicated by my initials below

**By *INITIALING*, I *DO NOT* agree for the following protected information to be released:**

_____ Drug & alcohol diagnosis/treatment

_____ ADD/Mental health diagnosis/treatment

_____ AIDS/HIV testing & high-risk behavior

_____ Genetic testing

_____ Family planning (birth control, tests, etc.)

*I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information. I am under no obligation to sign this form, and I may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan. I have the right to revoke this authorization at any time by providing a written request for revocation to Integrative Pediatrics. If I revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire 2 years*

X_____ _____ _____/_____/_____

Signature of Parent or Legally Responsible Person Print Name | Relationship Date

X_____ _____ _____/_____/_____

Signature of Patient 14+ years – REQUIRED Print Name Date