SKAGIT PEDIATRICS, LLP
2101 LITTLE MOUNTAIN LANE
MT. VERNON, WA 98274
Phone: (360) 428-2622 / Fax: (360) 428-3941

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

_____ _____
Name Date of birth

I hereby authorize the mutual exchange of information regarding the above named patient between:

Skagit Pediatrics, LLP
2101 Little Mountain Lane **AND** _____
Mt. Vernon, WA 98274 Agency/ Contact Persons

_____
Agency/Contact Persons

_____
Address

_____
Phone Number

Information to be released: ____All records ____Progress notes only ____Immunizations only

Specifically Exclude: _____

Purpose for which disclosure is being made: _____Doctor _____Insurance ____ Attorney ____Personal

I understand that my express consent is required for you to release information relating to sexually transmitted disease, mental illness, and/or drug/alcohol abuse, pursuant to Washington Law RCW 70.24 ET. SEQ.

If I have been tested, treated, or diagnosed in connection with any sexually transmitted disease, or drug/alcohol abuse, and/or mental illness, you are ***specifically authorized to release*** to the person or entity named above all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded above.

MY RIGHTS: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

CONSENT OF MINOR

Where a minor has the right to consent to medical treatment, he or she also has the right to control information related to that treatment. A competent minor patient's signature is required to release information related to care of: 1) birth control for minors deemed mature [WA case law]; 2) treatment for HIV/AIDS sexually transmitted diseases for patients age 14 and above; [RCW 70.05.070, RCW 70.24.110]; 3) to receive HIV/AIDS or STD test results for patients age 15 and above [RCW 70.24.105]; 4) outpatient treatment for alcoholism and drug abuse for patients age 13 and above; [RCW 70.96A.095]; and 5) mental health conditions for patients age 13 and above [RCW 71.34.030(1)]

Signature of minor:_____**Date**:_____

_____ _____ _____ _____
Parent/Guardian/Patient Signature **Relationship** **Date** **Phone**

This authorization expires _____days after the date signed. Not to exceed 1 year