DOC ID 089

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SNOHOMISH SCHOOL DISTRICT
CHERI PEACH
1601 AVENUE D
SNOHOMISH, WA 98290-1718

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ATTENTION

Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested, please call the phone number on the enclosed invoice.

To Whom It Concern:

CIOX has provided to you protected health information that may contain information that falls under the 42 C.F.R. Part 2. The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publically available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.112(c)(5) and 2.65.

If the enclosed record pertains to HIV/AIDs, it has been disclosed to you from records whose confidentiality is protected by federal and perhaps, state law, which prohibits you from making any further disclosure of such information without the specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for this release of health or other information is not sufficient for this purpose.

If the information requested is from a facility located within the Washington State area then this information will fall under the RCW 70.02.300 which states that this information has been disclosed to you from records who confidentiality may be protected by state law. State law prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of this protected information is not sufficient for this purpose.

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05/09/2019

SNOHOMISH SCHOOL DISTRICT
CHERI PEACH
1601 AVE D

SNOHOMISH, WA 98290-1718

[redacted]

Records Requested from: SEATTLE CHILDRENS HOSPITAL

Dear Requester of Healthcare Information:

IOD Incorporated has been retained by the above named Health Care Provider to handle release of information requests such as yours at their facility. Enclosed please find the information you requested with a copy of your request.

Please Note; This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65.

If you have requested x-ray films or billing records, you will need to contact the radiology department or billing office to check the status of your request. If you need information regarding x-ray or billing records, please contact the Health Care Provider directly.

Would you like to learn how IOD can assist your facility with requests for copies of medical records as well as meeting Meaningful Use requirements?

At little or no cost to you, IOD can ease the burden on your staff and help you stay compliant. In fact, you may even receive reimbursement. IOD's industry leading PRISM® technology and HIPAA-certified staff is led by credentialed managers and provides timely fulfillment of requests - within 48-72 hours on average. If you'd like to learn more about IOD's services, please email at sales@iodincorporated.com or call toll-free 844-479-0468.

If you have any questions regarding this notice, please contact Customer Relations at 866-420-7455 Option 1.

AUTHORIZATION TO EXCHANGE PATIENT HEALTH INFORMATION WITH SCHOOL

Patient Name: [redacted]

Seattle Children's Medical Record # (if known) _____ **Date of Birth** [redacted]

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): Snohomish School District Attn: Cheri Peach

Address 1601 Avenue D

City, State, Zip Snohomish WA 98290

Phone # (360) 563-7321 Fax # (360) 563-7303

Information to be Released to School/Contact:

Dates of service for records release: from 5/30/16 to Present

☒ Outpatient Clinic Notes ☐ Occupational Therapy Reports ☐ Physical Therapy Reports
☐ Discharge Summary ☐ Speech and Language Reports ☐ Nutrition Reports
☐ Other: ☐ Other: ☐

Information to be Obtained from School/Contact:

Dates of service for records requested: from 5/30/16 to Present

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

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 ☐ Everett Clinic ☐ Federal Way Clinic ☐ Olympia Clinic ☐ Tri-Cities Clinic
☐ Bellevue at Overlake Medical Tower ☐ South Sound Cardiology ☐ Pediatric Cardiology of Alaska ☐ Odessa Brown
☐ Other _____ ☐ 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.

[redacted]

Mother [redacted] 3-14-19 12:55
Relationship to Patient Date Signed Time Signed

Release Requiring Specific Consent- I spec ih information checked below:

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

_____ _____ _____ _____
Signature of Patient/Legal Representative Printed Name Date Time

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 Filing, OC.6.820.
For Release requests: Do you need HIM Department to send these records? Yes ☐ No ☐
If YES, send authorization to HIM, OC.6.820 If NO, place copy in chart, or send copy to HIM Filing, OC.6.820.

Name: _____ Clinic/Unit: _____ Ext: _____
Please Print

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

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

't Name: [redacted]

HEARING LEVEL [redacted] (ANSI 2003)

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[redacted]