Sheila Z. Kennedy, D.O.

820 Harvey Rd. Suite E, Auburn, WA 98002
Phone: 253-939-1066 Fax: 253-939-1069

FORMS/LETTERS

Frequently patients request the completion of forms or the creation of documents for some special need. In the past this was not as common an occurrence and I was able to do this as a courtesy. Due to the increasing number of requests and the burden of time to complete these requests, it has become necessary to charge a fee for these services. Health insurance does not cover this service. The fee therefore, becomes the responsibility of the patient requesting the service.

In order to expedite requests and keep costs to a minimum, the following information is required prior to any action being taken:

1. **All** pertinent information needed to complete the document must be provided prior to work being started on the document.

   - Name / Address and Fax number, if appropriate, of the person who is to receive the document.
   - Complete instructions regarding completion of the requested document. What information is required? What, if anything, should not or need not be supplied? What is the purpose of the letter requested, i.e. what is the expected outcome? You may use the same provided below.
   - Any applicable form that requires completion should be supplied with instructions as well as the Name / Address of the recipient.

2. Allow a minimum of 7-10 working days for completion of the requested documents.

3. A nonrefundable deposit of $50.00 is required to begin processing. This covers the basic processing and handling fees. Additional fees may apply depending on the complexity of the document. These fees, if applicable, will be required prior to the document being finalized.

4. No documents will be completed on verbal request only.

5. Your signature on page 2 of this document authorizes the release of the requested information, and acknowledges your understanding and acceptance of the fees to be charged.

Attach any written instructions, print or write legibly any other important instructions in this area.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name of person requesting letter:_____Relationship to Patient_____
Patient Name:_____ Date of Birth:_____
Previous Names used:_____ Social Security #_____

I request and authorize **Sheila Z. Kennedy, D.O.** at 820 Harvey Rd. Ste E Auburn, WA 98002 to release healthcare and/or financial information of the patient named above to:

Company/School Name:_____
Attention/Contact:_____
Street/Mailing Address:_____
City, State, Zip Code:_____
Phone:_____Fax:_____

This request and authorization applies to:

☐ Patient requested letter in regards to _____for the purpose of obtaining
health condition / diagnosis

_____
reason this letter is needed

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records(Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing this document, I am authorizing the release or exchange of these records to the parties named above.

Definition: A sexually transmitted disease is any disease, condition or dysfunction acquired through sexual activity of any kind. Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ :_____
Patient Signature (If patient is age 14 or older they must also sign) Date Signed

_____ _____
Parent or Guardian Signature (if patient is under age 14) Date Signed

THIS AUTHORIZATION IS IN EFFECT FOR NINETY DAYS