Patient Name: _____ Birthdate: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

I REQUEST MY HEALTHCARE PROVIDER

Provider Name: _____ Phone #: _____ Fax #: _____

Address: _____

TO RELEASE PROTECTED HEALTH INFORMATION TO:

EvergreenHealth Women's Care, Monroe 14841 179th Ave SE, Suite 310, Monroe, WA 98272

Phone #: 360.794.1444 Fax #: 360.805.3461

For the Purpose of: ☐ Continued Healthcare ☐ Other _____

Information obtained with this authorization will be used solely for the purpose defined above.

My Protected Health Information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinician office chart reports, laboratory reports, dental records, pathology reports, therapy reports, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I Authorize Release of: ☐All Protected Health Information ☐Specific Information: _____

Date(s) of Service for Requested Health Information: _____

This authorization includes the release of the following sensitive medical information unless specifically excluded (please check if you do not want this information released:
☐Sexually Transmitted Disease (STDs) ☐AIDS/HIV Diagnoses/Test Reports ☐Alcohol/Drug Abuse or Treatment
☐Mental Health

I understand that my records are protected under Federal and State Confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 CFR Part2). Staff from Evergreen Hospital Medical Center may discuss my medical conditions and treatment with those persons or organizations listed above. I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing.

REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of the Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules (42 CFR Part2). The Federal Rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2.

I understand that I do not have to sign this authorization in order to receive Health Care treatment.

Required: Expiration Date or Event: _____

Signature:_____ Date:_____
(If signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____

Relationship to Patient: ☐Parent ☐Legal Guardian* ☐Holder of a Durable Power of Attorney for Health Care*
*Please attach Legal Documentation if you are the Legal Guardian or Holder of a Durable Power of Attorney for Health Care

EvergreenHealth

REQUEST FOR HEALTHCARE INFORMATION

Form ID ADM535

APPLY PATIENT LABEL HERE