EvergreenHealth

Phone #: 425.899.1920
Health Information Management Department
12040 NE 128th Street, Kirkland, WA 98034

Hospital/Specialty Clinic Records: Fax #: 425.899.1933
Primary/Urgent Care Records: Fax #: 425.899.1918
Home Care Services: Fax #: 425.899.3251

Patient Name: _____ Birthdate: _____

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

Home Phone #: _____ Cell #: _____ Other: _____

I authorize EvergreenHealth_____ to release healthcare information to:
(specify which EvergreenHealth department or clinic)

Facility/Company: _____ Attention: _____

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

Phone #: _____ Fax: _____

I authorize the release/disclosure of the following healthcare information:

☐ Visit Note(s) ☐ ED Records ☐ Diagnostic Imaging Report(s) ☐ Laboratory Report(s)
☐ Pertinent Records ☐ Immunization Record(s) ☐ Diagnostic Imaging Film(s) ☐ Billing Record(s)
☐ Plan of Care ☐ Medication Record(s) ☐ Other (describe)_____

Dates of information to be disclosed: from_____ to_____

Purpose of disclosure: ☐ Insurance ☐ Legal ☐ Physician ☐ Self ☐ Research ☐ AFH/ALF ☐ Other _____

Is disclosure to an employer or financial institution? ☐ Yes ☐ No (if yes, authorization expires 1 year after signing)

This authorization may include the release of the following sensitive medical information **unless specifically excluded** (please check if you do **NOT** want this information released): ☐ Sexually Transmitted Disease
☐ AIDS/HIV Diagnoses Report(s) ☐ Alcohol/Drug Abuse or Treatment ☐ Mental Health

EvergreenHealth is hereby released from all legal responsibilities or liability for the release of the above-mentioned information.

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 Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules that 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 Part 2.

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 to the HIM Department at the address listed above. **I understand that I do not have to sign this authorization in order to receive Health Care treatment.** I further understand that if I request records for personal use, or for parties not involved in my health care, there may be a charge.
This authorization expires on_____ or when the following event occurs_____
If there is no expiration date given, this authorization will expire one year from the date of signature. If the disclosure is to an employer or financial institution this authorization expires 1 year after signing.

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 Power of Attorney* ☐ Executor of Estate*
*Please attach Legal Documentation if you are the Legal Guardian, Power of Attorney or Executor of Estate

PLEASE PROVIDE A COPY OF A GOVERNMENT ISSUED PHOTO ID

EvergreenHealth Kirkland, WA 98034

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

FORM ID ADM 536
Approved 11/14

APPLY PATIENT LABEL HERE

MR