Patient Name: _____ Birthdate: _____

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 Obstetrics and Gynecology Care, Coral, 12303 NE 130th Lane, Suite 420, Kirkland, WA 98034

Phone: 425.899.6400 Fax: 425.899.4490

Department: _____ Phone #: _____ Fax #: _____

For the Purpose of: ☐ Continued Healthcare ☐ Other _____

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: _____

Dates of service being requested: from _____ to _____

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 (STDs) ☐ AIDS/HIV Diagnoses/Test Reports ☐ Alcohol/Drug Abuse or Treatment

☐ Mental Health

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 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 to the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to the releasing provider. **I understand that I do not have to sign this authorization in order to receive healthcare treatment.**

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.

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 Kirkland, WA 98034

REQUEST FOR HEALTHCARE INFORMATION

FORM ID ADM 535-EWC420

Approved 05/14

Item ID 16386

APPLY PATIENT LABEL HERE

Original - Medical Record Copy - Patient

MR