EvergreenHealth OBSTETRICS & GYNECOLOGY CARE, TAN

Address:	Patient Name:		Birthdate:	
I REQUEST MY HEALTHCARE PROVIDER: Provider Name:				Zip:
Provider Name:	Home Phone #:	Work Phone #:	Cell #:	
Address:	I REQUEST MY HEALTHCA	RE PROVIDER:		
TO RELEASE PROTECTED HEALTH INFORMATION TO: EvergreenHealth Obstetrics and Gynecology Care, Tan, 12333 NE 130th Lane, Suite 110, Kirkland, WA 98034 Phone: 425.285.0060 Paint: 425.285.0070 Department:	Provider Name:	Phone #:	Fax #:	
TO RELEASE PROTECTED HEALTH INFORMATION TO: EvergreenHealth Obstetrics and Gynecology Care, Tan, 12333 NE 130th Lane, Suite 110, Kirkland, WA 98034 Phone: 425.285.0060 Paint: 425.285.0070 Department:				
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 records (including nursing records and progress notes), and any personal o medical information related to the purpose of this authorization. IAuthorize Release of: All Protected Health Information Specific Information:	EvergreenHealth Obstetrics	s and Gynecology Care, Tan, 12	333 NE 130th Lane, Suite 110, K	(irkland, WA 98034
Protected Health Information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital records (including nursing records and progress notes), and any personal o 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	Department:	Phone #:	Fax #: _	
diagnostic imaging reports, transcribed hospital reports, clinician office chart reports, laboratory reports, dental records, including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. If Authorize Release of: All Protected Health Information Specific Information: Dates of service being requested: from to a NOT want this information released: Secularly Transmitted Disease (STDs) AIDS/HIV Diagnoses/Test Reports Alcohol/Drug Abuse or Treatmere 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 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: (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* Presente Alegal Documentation if you are the Legal Guardian or Holder of a Durable Power of Attorney for Health Care* Presente Alegal Documentation if you are the Legal Guardian or Holder of a Durable Power of Attorney for Health Care* Presente Alegal Documentation if you are the Legal Guardian or Holder of a Durable Power of Attorney for Health Care	For the Purpose of: Contin	nued Healthcare D Other		
excluded (please check if you do NOT want this information released: Sexually Transmitted Disease (STDs) AIDS/HIV Diagnoses/Test Reports Alcohol/Drug Abuse or Treatmer 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 informatio 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	I Authorize Release of:	All Protected Health Information		
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Signature:Date:	in order to receive healthcare	e treatment.		
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 COUEST FOR HEALTHCARE INFORMATION FORM ID ADM 535-EWC420 Approved 05/14 APPLY PATIENT LABEL HERE Original - Medical Record Copy - Patient	This authorization expires on If there is no expiration date give	or whe ven, this authorization will expire	n the following event occurs one year from the date of signatur	re.
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FORM ID ADM 535-EWC420 Approved 05/14 Original - Medical Record Copy - Patient	_		APPLY PATIENT LA	BEL HERE
	FORM ID ADM 533 Approved 05/	5-EWC420	Original - Medical Record	Copy - Patient