Jefferson Healthcare
SWEDISH Health Network Affiliate

Status: Official
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Authorization to Obtain or Disclose Health Care Information

Contact Information: 834 Sheridan Street Phone #: 360-385-2200 Toll Free #: 800-244-8917 Fax #: 360-379-2286

Patient Name: ______________________ **Date of Birth:** ______________________

Previous Name: ______________________ **Phone #:** ______________________

Release records from:	Release records to:
Facility/Name: ______________________	Facility/Name: ______________________
Address: ______________________	Address: ______________________
______________________	______________________
Phone #: ______________________	Phone #: ______________________
Fax #: ______________________	Fax #: ______________________

You may disclose the following health care information:

☐ Diagnostic Imaging and Reports on CD (fee may apply).
☐ Two years of health care information in my record up to and including the most recent dates of service.
☐ Health care information in my record relating to the following treatment and/or dates of service:

____

Release my records in the following format:

☐ Paper ☐ Electronic (media, flash drive, CD) ☐ My Chart (maximum file size to release is 1.0 GB)

Do NOT send records regarding (check any that apply):

☐ HIV/AIDS ☐ Sexually Transmitted Diseases
☐ Psychiatric Disorders/Mental Health ☐ Drug and/or Alcohol Use

Patient Access Requests may skip this section

Reason(s) for this authorization (check all that apply):

☐ At the request of the patient (a fee may apply) ☐ Transfer of Care / Continuity of Care
☐ Legal (a fee may apply) ☐ Insurance

☐ Other: ____

Document Purpose: Authorization to release PHI
Owner: Melody Draper Department: Health Information Management
Reference (Policy, Procedure, Other): Release of Information
Revision Date: 07/2016 *Review Date:* 11/2017

Paper copies of this document may not be current and should be verified before use. The current version can be found at
Document Path: X:\Public\Forms\FORMS\HIM

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This authorization will automatically end 90 days after the date it is signed, unless an earlier date is specified below:

☐ This authorization ends: ______________________________

Patient Rights
I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance. Otherwise, I may revoke this authorization at any time. Revoking this authorization will not affect any actions already taken by Jefferson Healthcare. I may revoke this authorization by:

1) Filling out a revocation form, or
2) Writing a letter to notify the Health Information Management Department at Jefferson Healthcare.

I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.

I understand that I do not have to sign this authorization in order to receive health care treatment.

______________________________	______________________________
Patient signature (or legally authorized individual)	**Date**
______________________________	______________________________
Printed name (if signed on behalf of the patient)	**Relationship to patient**