Jefferson Healthcare
SWEDISH Health Network Affiliate

**Status:** Official
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**Archived:** N/A

# 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: | Jefferson Healthcare | Facility/Name: | |
| Address: | 834 Sheridan Street | Address: | |
| | Port Townsend WA 98368 | | |
| Phone #: | 360-385-2200 | Phone #: | |
| Fax #: | 360-379-2286 | 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
☐ Psychiatric Disorders/Mental Health
☐ Sexually Transmitted Diseases
☐ 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)
☐ Legal (a fee may apply)
☐ Transfer of Care / Continuity of Care
☐ 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

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# Authorization to Obtain or Disclose Health Care Information

**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**



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