SWEDISH

Community Health Medical Home

Authorization for Disclosure of Health Information

I hereby authorize *Dr.* _____ to disclose the following information from the records of:

Clinic _____

Address _____

City _____ *State* _____ *ZIP* _____

Phone _____ *Fax* _____

Patient Name: _____ (*Last, First, Middle*)

Previous Name: _____ (*Last, First, Middle*)

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ – _____ Social Security Number: _____ – _____ – _____

Birth date: _____ Dates of Medical Care: _____

To be disclosed to: **Swedish Community Health Medical Home**
5300 Tallman Ave. N.W., Seattle, WA 98107
Telephone 206-297-5100 Fax 206-297-5151

Information to be disclosed:

☐ History & Physical ☐ Progress (Chart) Notes ☐ Discharge Summary

☐ Emergency Department Report ☐ Operative Report ☐ Diagnostic Studies (Labs, X-ray, EKG, etc.)

☐ Other _____

For the purpose of: _____

If requesting birth records, include mother's name and newborn's time of birth: _____

I understand that this authorization covers all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions. I understand that if I wish to exclude any of the above, I may attach a separate statement.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal or state confidentiality laws.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment at Swedish Community Health Medical Home.

Expiration date or event _____ *

*Authorization for disclosure to a financial institution or employer of the patient for purposes other than payment for health-care services expires 90 days after date signed.

Signed: _____ Date: _____
(Patient)

_____ Date: _____
(or Legal Representative and Relationship)

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