I understand the following:

• I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

• There may be a fee associated with this request.

• Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

• I have the right to receive a copy of this signed authorization.

• I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when Swedish has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

Please submit this authorization or revocation to one of these locations, depending on where you received care:

Swedish Medical Center
Release of Information Department
747 Broadway, Seattle, WA 98122
Phone/Fax: (206) 320-2626
Email: ROI@swedish.org

Swedish Medical Group
605 South Queen Anne Road, Suite 210
Seattle, WA 98121
Phone: (206) 320-3025
Fax: (478) 238-9436
Email: smgroi-wa@cioxhealth.com
Important: Swedish no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

Swedish Health Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

Swedish Health Services (888) 311-9127 (TTY: 711)

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (TTY: 711).

I authorize Swedish to use and disclose a copy of the specific health information described below regarding:

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

To be disclosed to: Self or Recipient's Name:

Recipient's Address:

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

Please send my records via: MyChart Email Disc Paper Fax

I am requesting information from the following facility(s):

<table>
<thead>
<tr>
<th>Hospital Name (List) &amp; Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Clinic Name (List) &amp; Phone Number</th>
</tr>
</thead>
</table>

For the range of dates from: to:

For information related to the following diagnosis or injury:
ការអនុញ្ញាតអោយអ្រើ្ាស់រង្ហិន & ចែកចាយពត៌មានសុខភាពចែកចាយរកាទុក

Information to be disclosed:

☐ ប្រទេស & ការសិក្សាទូទៅ/History & Physical
☐ បាយការណ៍/Operative Report
☐ បាយការណ៍សម្រាប់អេស្រាត (អធិការណ៍, ការរឹងចិត្ត, EKG ជាដំបូង)
  Diagnostic Reports (lab, x-ray, EKG, etc.)
☐ អំពី槟 (អប់រំ/Other (specify):

For the purpose of:

ប្រការអនុញ្ញាត អោយអ្រើ្ាស់ នឹងការអនុញ្ញាតអនុះនឹងព្ងីកែល់គរ់រូរភាពទុំងអស់ថ្នការអធវើអតសត និង/ឬការពយាលជុំងឺកាមអោគជុំងឺ AIDS ការឆ្កងអមអោគ HIV ការផ្ឹក្ានិង/ឬអ្រើ្ាស់អ្គឿងអញៀន ន្ទការែុញុំការោយសម្រាប់ការអនុញ្ញាត អោយអ្រើ្ាស់ ជាពីរជាតិបក្សពីអនុញ្ញាត អោយអ្រើ្ាស់ រដ្ឋបាលពីការែុញុំការោយសម្រាប់ការអនុញ្ញាត អោយអ្រើ្ាស់

Terms: This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Patient Signature: _______________________________ កាលររិអែឆទ/
(Print form and sign by hand)

Patient Representative Name:

Patient Representative Signature: _______________________________ កាលររិអែឆទ/
(Print form and sign by hand. Please include supporting documentation.)

Relation to Patient:

1ROI