

AUTHORIZATION TO USE, DISCLOSE, & RELEASE PROTECTED HEALTH INFORMATION

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

Fax: 206-320-2626

**Swedish Medical
Group**

**Centralized Services
Department**

800 5th Ave, Suite 800

Seattle, WA 98104

Fax: 425-454-2935

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.

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.

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.

ATTENTION: If you speak English, you have at your disposal free language assistance services. Call 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).



AUTHORIZATION TO USE, DISCLOSE, & RELEASE PROTECTED HEALTH INFORMATION

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

Patient's Name: _____

DOB: _____ **Patient's Address:** _____

_____ **Phone:** _____

To be disclosed to:

(Name of Recipient(s)): _____

Recipient's Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

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

Hospital Name (List) & Phone Number	Clinic Name (List) & Phone Number

For the range of dates from: _____ to: _____

For information related to the following diagnosis or injury: _____

Information to be disclosed:

- History & Physical
- Discharge Summary
- Operative Report
- Emergency Department Report
- Diagnostic Reports (lab, x-ray, EKG, etc.)
- Progress Notes
- Other (specify): _____

For the purpose of: _____

Unless revoked, this authorization expires in 180

days or on this Date: _____

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: _____ **Date:** _____

Patient Representative

Name: _____ **Date:** _____

Patient Representative

Signature: _____

Relation to Patient: _____