

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION



Health Information Management Department 1200 12 th Ave S., Suite 901, Seattle, WA 98144 / T: 206.548.3043 / F: 206.461.8382 E-mail : healthrecords@neighborcare.org		MEDICAL RECORD NUMBER (optional)	
Patient Information			
Patient Name:		Date of Birth: / /	
Previous Name:		Phone Number:	
Information To Be Released FROM:		Information To Be Released TO:	
<input type="checkbox"/> Neighborcare Health	<input type="checkbox"/> Other (see below)	<input type="checkbox"/> Neighborcare Health	<input type="checkbox"/> Other (see below)
Name:		Name:	
Address:		Address:	
City:	State:	Zip:	
Phone:	Fax:	Phone:	Fax:
How Do You Want Your Records Delivered? (Select one. Records will be sent on paper if not specified)			
<input type="checkbox"/> Paper	<input type="checkbox"/> CD	<input type="checkbox"/> Encrypted Email (enter email address):	
Why Is This Information Being Released?			
<input type="checkbox"/> Transfer of Care	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Legal Use	
<input type="checkbox"/> Other:			
What Type of Information Do You Want Released?			
<input type="checkbox"/> All records for the past year	<input type="checkbox"/> All records for All dates of service	<input type="checkbox"/> Immunization records	
<input type="checkbox"/> Most recent Lab results	<input type="checkbox"/> Most recent TB test results	<input type="checkbox"/> Most recent Radiology results	
<input type="checkbox"/> Other (specify):			
Verbal Communication			
<input type="checkbox"/> I authorize Neighborcare Health to verbally discuss my medical care with the person specified above.			
Sensitive Information			
Unless otherwise specified by me below, I authorize all sensitive information to be released including testing, diagnosis or treatment of mental/psychiatric illness, drug and/or alcohol use, HIV/AIDS, or sexually transmitted diseases.			
<input type="checkbox"/> I do NOT authorize this information to be released.			
Expiration Date			
This authorization will expire <i>one year</i> from the date signed below unless otherwise listed: / /			
My Rights as a Neighborcare Health Patient			
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study when the purpose is to create healthcare information for a third party.			
I may revoke this authorization at any time by submitting a written request to Neighborcare Health. This will not apply to any information released prior to receipt of the written request.			
Once health care information is disclosed, the person or organization that receives it may re-disclose it, and the information may no longer be protected by HIPAA or other privacy laws.			
Signature of Patient * or Legal Guardian			
If signed by someone other than the patient or legal guardian, then please provide documentation authorizing you to sign.			
Signature:	Print Name:	Date:	
	Relationship to Patient:	/ /	
Minor Consent (Minors age 13-17 are required to sign to authorize the release of information).			
Signature of Minor:	Print Name:	Date:	
		/ /	

*Patients age 18+, as well as some minor patients, have the right to request copies of their own medical records.