AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

neighborcare health

Neighborcare Health / Health Information Management Department 1200 12th Ave S., Suite 901, Seattle, WA 98144 / T: 206.548.3043 / F: 206.461.8382	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:**		
☐ Neighborcare Health	☐ Other (see below)		☐ Neighborcare Health	☐ Other (see below)	
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	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)		
☐ Paper	☐ CD	☐ Encrypted Email (enter email address):

Why Is This Information Being Released?		
☐ Transfer of Care	☐ Personal Use	☐ Legal Use
☐ Other:		

What Type of Information Do You Want Released?		
☐ All records for the past year	☐ All records for All dates of service	☐ Immunization records
☐ Most recent Lab results	☐ Most recent TB test results	☐ Most recent Radiology results
☐ Other (specify):		

Verbal Communication
☐ 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.
☐ I do *NOT* authorize this information to be released.

Expiration Date
This authorization will expire *one year* 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: / /

Minor Consent (Minors age 13-17 are required to sign to authorize the release of information).		
Signature of Minor:	Print Name:	Date: / /