AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

neighborcare health

Health Information Management Department 1200 12th 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:**		
☐ 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):	☐MyChart

Why Is This Information Being Released?

☐ Transfer of Care	☐ Personal Use	☐ Legal Use
☐ Other:		

Physical Records to be Released

☐ All records for the past year	☐ All records for All dates of service	☐ Immunization records
☐ Most recent Lab results	☐ Most recent dental records/x-rays only	☐ Most recent Radiology results
☐ Other (specify):		

Verbal Communication ONLY (checking this box means no physical records will be released)

☐ I authorize Neighborcare Health to verbally discuss my dental/ 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, please provide documentation authorizing you to sign.

Signature:	Print Name: Relationship to Patient:	Date: / /

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 Updated on 06/25/2025**

Language**: English**

Do you need your medical records sooner?

Submit an online request via our secure website. Scan the QR Code below or visit neighborcare.org/records.

Please note:

- You will need to upload a copy of your driver's license or government-issued identification to access your medical records through our secure website.
- Dental records and X-rays cannot be requested via our online records request website; you will need to complete and submit this printed form.