SWEDISH

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	**Swedish Medical Group**
Release of Information **747 Broadway** **Seattle, WA 98122** **Phone: (206) 320-3850** **Fax: (206) 320-2626**	**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.

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).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 **(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: _____

Date of Birth: _____

Prior Name(s) Used: _____

Patient's Address: _____

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

Phone: _____ **Email:** _____

Please disclose my records to: **Myself** ☐

or the following recipient ☐

Recipient Name: _____

Address: _____

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

Fax: _____ **Email:** _____

Please send my records via:

☐ **MyChart** ☐ **Email** ☐ **Disc**

☐ **Fax** ☐ **Paper**

I am requesting records from the following Facility(s):	
Hospital(s)/Provider Name	**Clinic(s)/Provider Name**

For the range of dates from:

_____ **to:** _____

Information to be disclosed:

☐ **History & Physical**
☐ **Operative Report**
☐ **Diagnostic Report**
☐ **Last 2 years only**
☐ **Discharge Summary**
☐ **Emergency Dept Report**
☐ **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:
(Print form and sign by hand) _____

Date: _____

Patient Representative: _____

Representative Signature: _____

Relationship to Patient: _____

Date: _____