EvergreenHealth

Releasing Department: **EvergreenHealth Professional Billing Office**
12040 NE 128th Street, MS-10
Kirkland, WA 98034
Phone #: 425.899.3292 Fax #: 425.899.3269

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

I Authorize EvergreenHealth to release healthcare information to:

Insurance Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose of Disclosure: ☒ Insurance ☐ Attorney ☐ Legal ☐ Physician ☐ Self ☐ Research ☐ Other _____

Is Disclosure to an employer or financial institution? ☐ Yes ☐ No (if yes, authorization expires 90 days after signing)

HEALTH INFORMATION TO BE DISCLOSED / RELEASED:

Dates of service being requested: from _____ **to** _____

☐ Last Visit Note dated _____ ☐ ED Records ☐ Diagnostic Imaging Report(s) ☐ Laboratory Report(s)
☐ Pertinent Records (last 2 yrs) ☐ Immunization Record(s) ☐ Diagnostic Imaging Film(s) ☒ Billing Records
☒ Progress Notes ☐ Other (please describe) _____

This authorization may include the release of the following sensitive medical information **unless specifically excluded** (please check if you do **NOT** want this information released): ☐ Sexually Transmitted Disease
☐ AIDS/HIV Diagnoses Report(s) ☐ Alcohol/Drug Abuse or Treatment ☐ Mental Health

EvergreenHealth is hereby released from all legal responsibilities or liability for the release of the above-mentioned information.

REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to the HIM Department at the address listed above. **I understand that I do not have to sign this authorization in order to receive Health Care treatment.** I further understand that if I request records for personal use, to hand carry to another health care provider, or for parties not involved in my health care, there may be a charge. **This authorization expires on** _____ **or when the following event occurs** _____
If there is no expiration date given, this authorization will expire one year from the date of signature. If the disclosure is to an employer or financial institution this authorization expires 90 days after signing.

Signature: _____ Date: _____
(If signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Holder of a Power of Attorney*
*Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

PLEASE PROVIDE A COPY OF A GOVERNMENT ISSUED PHOTO ID

EvergreenHealth Kirkland, WA 98034

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION-PRO FEE BILLING

FORM ID ADM 536-Insurance
Approved 10/13

APPLY PATIENT LABEL HERE

MR