

FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Healthcare Provider or Healthcare Organization _____

to disclose the following information from the health records of:

Patient Name: _____ (Last, First, Middle)

Previous Name: _____ (Last, First, Middle)

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____ Social Security Number: _____ - _____

Birth date: _____ Dates of Medical Care: _____ - _____

To be disclosed to: _____ (Name)

(one recipient only) _____ (Attention)

_____ (Address)

_____ (City, State, ZIP)

(_____) _____ - _____ (Telephone) (_____) _____ - _____ (FAX)

Information to be disclosed:

History & Physical

Discharge Summary

Operative Report

Diagnostic Studies (Labs, X-ray, EKG, etc.)

Progress (Chart) Notes

Emergency Department Report

Other _____

For the purpose of: _____

If requesting birth records, include mother's name at patient's time of birth: _____

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

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.

I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment at Swedish Medical Center.

Expiration date or event _____ *

*Authorization for disclosure to a financial institution or employer of the patient for purposes other than payment for healthcare services expires 90 days after date signed.

Signed: _____ Date: _____

(Patient)

_____ Date: _____

(or Legal Representative and Relationship)