



Authorization To Release Patient Health Information

This form may also be used for a patient to authorize the use or disclosure of their health information to Neighborcare Health from another organization.

Patient Name: _____ Date of Birth : ____/____/____

Previous Name (if applicable) _____

Reasons(s) for this authorization (Check all that apply):

I wish to receive my records electronically on a disc/CD

Personal Use Transfer to another provider Legal Use Continuing Care Other (specify): _____

Information to be Released FROM:		Information to be Released TO:	
<input type="checkbox"/> Neighborcare Health or		<input type="checkbox"/> Neighborcare Health or	
_____ Organization or Company		_____ Organization or Company	
_____ Address	_____ City, State, Zip	_____ Address	_____ City, State, Zip
_____ Phone	_____ Fax	_____ Phone	_____ Fax

Information to be Disclosed/Released

Neighborcare Health may use or disclose the following healthcare information (check all that apply):

Entire Completed Chart Record

OB Reports: All Specify: _____

Labs/Reports: All Specify: _____

Immunization/Shot Records

All Other Medical History (Please Specify): _____

This authorization will expire one year from the date signed below unless another date or an event is entered here: _____

Releasing Sensitive Information-IMPORTANT

I authorize the release of the following sensitive information. Please check the applicable boxes below to request the following records:

HIV (AIDS virus) Sexually Transmitted Diseases Mental Health Drug and/or alcohol use

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 or

* To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Neighborcare Health or the organization indicated above where my information is being released to.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient/Legally Authorized

Patient or legally authorized individual signature Date Time

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

ADMINISTRATIVE OFFICE | Health Records Dept | 1200 12th Ave S, Suite 901, Seattle, WA 98144 • Phone: 206-548-3043 • Fax: 206-461-8382

Dental Clinics | 45th Street • Central Area • Georgetown • High Point • Rainier Beach
Medical Clinics | 45th Street • Homeless Youth • Ballard Homeless Clinic • Columbia City • Greenwood • High Point • Lake City • McDermott Place • Meridian • Pike Market • Rainier Beach • Saint Vincent De Paul
School Based Health Centers | Bailey Gatzert Elementary • Chief Sealth International High School • Dearborn Park International School • Denny International Middle School • Hamilton Middle School • Highland Park Elementary • Madison Middle School • Mercer Middle School • Roosevelt High School • Roxhill Elementary • Seattle World School • Van Asselt Elementary • West Seattle Elementary • West Seattle High School