I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize _____ **[Insert Facility/Clinic]** to use and disclose the protected health information as described below for the following patient:

Patient Name: _____ DOB: _____

Patient Previous/Other Name(s):_____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email*: _____

**Valid Email required for an electronic release*

The following individually identifiable health information may be used and/or disclosed:

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.**)

Check (√) all that apply:

— Abstract (Includes[1])
— Discharge Summary /Final Diagnosis[1]
— History and Physical Records[1]
— Consultation Reports[1]
— Operations and Procedures[1]
— Results of Diagnostic Testing[1]
— Emergency Room Records
— Lab Reports
— Radiology (for example: X-Ray) Reports
— Other Diagnostic Reports
— Diagnostic Images (Prepped by Radiology Dept)
__ Immunization (shot) Record
__ Physical Therapy Notes
__ Physician Notes
__ Medication List
__ Itemized Bill

— Other**: _____

Dates of treatment to be released: From:_____ To:_____

Reason or purpose for the use and/or disclosure of the information:

_____

I request the form of release of information be ____ *Electronic (HIM Department Portal) **Email needed*

____ Paper (U.S. Mail or pick up) ____ Other (*USB, etc...****) _____

***Device must be provided by the facility

08/03/21

Virginia Mason Franciscan Health™

AUTHORIZATION FOR USE OR DISCLOSURE OF / ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: The healthcare provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 1 year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Facility's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.

If this authorization is for marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of PHI. ___*Yes* ___*No*

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE (Required)**

_____

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____

(Please include supporting documentation such as Power of Attorney documents, or other documents establishing status as the personal representative, when applicable.)

Virginia Mason Franciscan Health™

AUTHORIZATION FOR USE OR DISCLOSURE OF / ACCESS TO PROTECTED HEALTH INFORMATION

This authorization form may be sent to us by fax:

St. Joseph Medical Center
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: fhsmedicalrecords@chifranciscan.org

St. Anthony Hospital
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: fhsmedicalrecords@chifranciscan.org

St. Anne Hospital
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: fhsmedicalrecords@chifranciscan.org

St. Clare Hospital
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: fhsmedicalrecords@chifranciscan.org

St. Elizabeth Hospital
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: fhsmedicalrecords@chifranciscan.org

St. Francis Hospital
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: fhsmedicalrecords@chifranciscan.org

St. Michael Medical Center
HIM Department
Fax: (253) 426-6924
Phone: (253) 426-6673
Email: himroi@chifranciscan.org

Franciscan Medical Group
HIM Department
Fax: (253) 779-6245
Phone: (253) 792-2400
Email: fmgmedicalrecords@chifranciscan.org