Authorization For Release Of Health Care Information

EVIVA

Patient Name (include previous name): _____ Date of Birth: _____

Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____

I. Information to be released FROM (check ONLY one)

❑ **Eviva:** 19930 Ballinger Way NE, Shoreline, WA 98155
Phone: 425.778.2220 Fax: 425.776.7132

❑ Doctor's name/clinic or organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

II. Information to be released TO (check ONLY one)

❑ **Eviva:** 19930 Ballinger Way NE, Shoreline, WA 98155
Phone: 425.778.2220 Fax: 425.776.7132

❑ Doctor's name/clinic or organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

❑ Self

❑ I Give Eviva permission to send my health information over email Email: _____

III. What information do you want released (check all that apply):

❑ All Information ❑ Specific information (please specify) _____
❑ Information from date (you MUST indicate dates): _____ to date _____
❑ Mental health records ❑ Billing records ❑ Radiology Images

IV. Purpose of release (check all that apply):

❑ Doctor ❑ Personal Use ❑ Insurance ❑ Medical Leave ❑ Legal
❑ Other: _____

V. Patient Authorization - I understand that:

- Eviva Medical Center may not condition treatment, payment, enrollment, or eligibility for benefits (45 C.F.R. § 164.508(c)(2)).
- Records released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released.
- I may revoke this authorization in writing. My revocation would not affect any actions already taken by EVIVA Medical Center based upon this authorization.
- Health care information used or disclosed pursuant this authorization may be subject to re-disclosure and may no longer be protected by federal law.

VI. This authorization expires:

☑ In 90 days from the date signed ❑ On date or event (Please indicate): _____

VII. Signature:

_____ _____
Patient/Guardian or Authorized Representative (Documentation required to sign on behalf of the patient) Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, authorized representative)