AUTHORIZED AGENT:

KNOX ATTORNEY SERVICE, INC. / KNOX SERVICES, LLC.

Evergreen Hospital Medical Center
12040 NE 128th Street, Kirkland, WA 98034
Medical Records Department
Phone #: 425.899.1920 Fax #: 425.899.1933

Releasing Department: _____
Phone # _____ Fax # _____
MRN # _____ (for hospital use only)

Patient Name: _____ Birthdate: _____ SS#: _____

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

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

I Request/Authorize Evergreen Hospital Medical Center to release healthcare information to:

Name: _____ Phone #: _____ Fax #: _____

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

Purpose of Disclosure (please check one):

☐Insurance ☐Attorney ☐Legal ☐Physician ☐Self ☐Research ☐Other _____

Is Disclosure to an employer or financial institution? ☐ Yes ☐ No

HEALTH INFORMATION TO BE DISCLOSED / RELEASED:

☐All Medical History ☐Billing Records ☐Diagnostic Imaging Films
☐Diagnostic Imaging Reports ☐Emergency Department Records ☐Laboratory Reports
☐Other (please describe) _____

This authorization includes the release of the following sensitive medical information unless specifically excluded (please check if you do not want this information released:
☐Sexually Transmitted Disease (STDs) ☐AIDS/HIV Diagnoses/Test Reports ☐Alcohol/Drug Abuse or Treatment
☐Mental Health

EVERGREEN HOSPITAL MEDICAL CENTER is hereby released from all legal responsibilities or liability for the release of the above-mentioned information. I understand that my records are protected under Federal and State Confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 CFR Part2). Staff from Evergreen Hospital Medical Center may discuss my medical conditions and treatment with those persons or organizations listed above. 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.

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 the Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules (42 CFR Part2). The Federal Rules 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 Part2.

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.

Required: Expiration Date or Event: _____ (Note—if the disclosure is to an employer or financial institution, this authorization will expire 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

EVERGREEN HOSPITAL MEDICAL CENTER

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

APPLY PATIENT LABEL HERE

FORM ID ADM 536
Rev: 03/06

Original – Medical Record