I, _____ _____ xxx - xx - _____ _____
Patient or Personal Representative Name | DOB | SSN (last four digits) | Phone Number

HEREBY AUTHORIZE THE FOLLOWING:

☐ St. Joseph Medical Center ☐ St. Anthony Hospital ☐ St. Clare Hospital ☐ St. Francis Hospital
☐ St. Elizabeth Hospital ☐ Harrison Medical Center ☐ Highline Medical Center ☐ Regional Hospital
☐ Franciscan Medical Group: _____
Clinic Name: _____ Provider Name: _____
☐ Harrison HealthPartners: _____
Clinic Name: _____ Provider Name: _____

PURPOSE OF DISCLOSURE:

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) _____

DATES TO BE RELEASED
☐ Most recent two years
☐ Most recent five years
☐ All dates
☐ Specific dates for care received:
From ___/___/___ Through ___/___/___

INFORMATION TO BE RELEASED	
☐ Clinic Notes	☐ ED Records
☐ Immunization Records	☐ Discharge Summaries
☐ Lab Reports	☐ History and Physicals
☐ EKG Reports	☐ Consultations
☐ Pathology Reports	☐ Surgery/Procedure Reports
☐ Radiology Reports	☐ Films/Images
☐ Billing Records	☐ All Records
☐ Other (specific type) _____	

RELEASE INFORMATION TO:

Organization/Person: _____ Address: _____

City, ST., Zip: _____ Phone/Fax: _____

If requesting a copy of your own records, how would you like to receive this information? **Paper** ☐ **CD** ☐ **Pick-up** ☐

I AUTHORIZE _____ TO PICK UP THE ABOVE RECORDS.

Patient's Additional Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric condition and genetic testing. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment unless specifically excluded (please check if you do **NOT** want this information released):
☐ HIV/Aids ☐ Sexually Transmitted Disease ☐ Alcohol/Drug Abuse or Treatment ☐ Mental Health ☐ Genetic Testing

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

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 **CHI Franciscan Health's** Notice of Privacy Practices.

EXPIRATION: This authorization will expire when the request has been filled, or on this date: _____

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature (Patient or Person Authorized to Give Authorization)	*Date:*	*Time:*
If signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Their Authority		

596065

(05/26/15)

CHI Franciscan Health

AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)

Patient Information

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

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 your 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.

* If authorization is for *marketing,* indicate if **CHI Franciscan Health** will receive compensation in exchange for the use and/or disclosure of the PHI. _____ Yes or ____ No

Prohibition on Conditioning of Authorization: CHI Franciscan Health 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).

Revocation: I understand that I may revoke this authorization at any time by notifying **CHI Franciscan Health** in writing or completing the *Revocation of Authorization* form. I understand that if I revoke this authorization, it will not affect any actions that **CHI Franciscan Health** took before it received my revocation letter. For example, **CHI Franciscan Health** cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This authorization form may be sent to us by fax:

St. Joseph Medical Center
HIM Department
Fax: 253-426-6924
Phone: 253-426-6672

St. Anthony Hospital
HIM Department
Fax: 253-426-6924
Phone: 253-530-2277

St. Clare Hospital
HIM Department
Fax: 253-426-6924
Phone: 253-985-6686

St. Francis Hospital
HIM Department
Fax: 253-944-7916
Phone: 253-944-4150

St. Elizabeth Hospital
HIM Department
Fax: 360-802-8519
Phone: 360-802-8510

Harrison Medical Center
HIM Department
Fax: 360-744-6607
Phone: 360-744-6600

Highline Medical Center
HIM Department
Fax: 206: 241-6945
Phone: 206-431-5345

Regional Hospital
HIM Department
Fax: 206-241-6945
Phone: 206-431-5345

Franciscan Medical Group
HIM Department
Fax: 253-792-4993
Phone: 253-792-2400

Harrison HealthPartners
Medical Records Department
Fax: 360-744-6445
Phone: 360-744-6450

Franciscan Medical Group patients may pick up their medical record copies at either of the following locations:

- 1708 S. Yakima Ave, Lobby Level - Tacoma, WA 98405
- 16251 Sylvester Rd. SW, HIM Department - Burien, WA 98166

Please visit CHIFRANCISCAN.ORG to obtain the mailing address of the above facilities.

◇◇

FACILITY STAFF USES:

Request Received By: ______________________________ Date: ____________________

COPY OF AUTHORIZATION PROVIDED: ____Yes ____No FEE SCHEDULE PROVIDED: ______Yes ______No

The Personal Representative presented the following documentation to demonstrate their authority to act on behalf of the patient:

______ Power of Attorney ______ Death Certificate ______ Executorship ______ Court Order

Authorized Personal Representative notified that records were ready on Date: ______________ Employee Initials ________

____ ____________________

Signature of person picking up records Date

Type of photo identification verified: ___ Driver's License ___ Military I. D. ___ Other ______________ Employee Initials _____

CHI Franciscan Health

Patient Information

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)