AUTHORIZATION TO DISCLOSE OR USE HEALTH CARE INFORMATION

I hereby authorize Overlake Hospital Medical Center or Overlake Medical Clinics to release the following medical information as described below. My signature appears on reverse.

Patient whose records are to be released:	**For what purpose:**
Name: _____ Date of birth: _____ Phone: _____	[__] Sharing with other healthcare provider [__] Personal use [__] Insurance claim [__] Legal case [__] Other (specify): _____

Information sent from (choose):	**Information sent to:**
[__] Overlake Hospital Medical Center 1035 116th Ave NE Bellevue, WA 98004 Fax: 425-467-3343 [__] Overlake Medical Clinics Fax: 425-233-6286 Provider name or specialty: _____	Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____

Information to be released (choose):	**For approximate date(s) or condition:**
[__] Medical records of inpatient or clinic treatment	
[__] Summary of medical records for last two years, including doctors' reports, lab, x-ray & ECG reports	
[__] Laboratory results	
[__] Imaging (x-ray) or cardiology reports	
[__] Images from x-ray or cardiology (pictures on disk)	
[__] Billing records	
[__] Other records (specify)	

(Over)

OVERLAKE MEDICAL CENTER + OVERLAKE MEDICAL CLINICS

I understand that my health record may include information relating to sensitive topics. If my records are about this/these topics, I initial here to say I do NOT want them released.

Information to be excluded (initial):	
[___] Drug or alcohol abuse diagnosis or treatment	[___] HIV/AIDS testing or treatment
[___] Sexually transmitted diseases	[___] Mental illness, psychiatric diagnosis or treatment

Authorization:
I authorize the release of my medical records as described above. I do so voluntarily. This authorization expires 90 days after I sign it unless I specify an expiration date or event.

I have the right to revoke this authorization at any time. If I revoke the authorization, I will do so in writing to the Health Information Management department at the "Sent From" address above. If information has already been released based on this authorization, the revocation will not apply to that information. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the information has been disclosed, privacy regulations may not protect it from re-disclosure by the recipient.

I understand I do not have to sign this authorization in order to ensure health care treatment, payment, enrollment or eligibility for benefits. Depending on the use of the records, a copy fee may apply.

_____ _____ _____

Signature of Patient or Legal Representative* **Date** **Relation to Patient**

Please indicate if you would like a copy of this form [__] Yes [__] No

* If Legal Representative, provide documents to prove your authority to sign on the patient's behalf.
[___] Written patient authorization
[___] Medical power of attorney for health care decisions
[___] Patient deceased, next of kin or executor for patient's estate
[___] Other _____

Method of delivering information:
[___] I will pick up the information in the Health Information Management department.
[___] Please mail the records.
[___] Please release the records to my online portal ONE Chart (available after 3/8/15).
[___] I will review the records onsite in the Health Information Management department. I will call to schedule an appointment (OHMC 425-688-5643, OMC 425-635-6310).

For office use:
Date received: _____ Copy made: _____
Date released: _____ Employee initials: _____
ID of person picking up records: _____