

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

**Information to be released to \_\_\_ /from\_\_\_:** Stevens Hospital  
21601 76th Avenue West, Edmonds, WA 98026

**Information to be released to \_\_\_ /from\_\_\_:** \_\_\_\_\_  
Facility Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State, Zip Code (\_\_\_\_\_) Phone Number

**Information to be released:**

- The most recent 2 years of pertinent information (Treatment and diagnostic reports)
- All medical records
- Specific information (Please indicate dates of service): \_\_\_\_\_

**Purpose for which disclosure is being made:** (Please check one of the following)

- Healthcare
- Insurance
- Personal
- Legal
- Other: \_\_\_\_\_

**Patient Authorization:**

I understand that my records may contain information requiring special consent for disclosure. My initials below specifically authorize the release of healthcare information relating to the testing, diagnosis and/or treatment for:

- \_\_\_\_\_ Drug/alcohol abuse
- \_\_\_\_\_ Sexually-transmitted diseases
- \_\_\_\_\_ HIV/AIDS
- \_\_\_\_\_ Mental health/psychiatric disorders

**My Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that I may revoke this authorization in writing. (To view the process for revoking this authorization, please read the Notice of Privacy Practices posted on [www.StevensHospital.org](http://www.StevensHospital.org) and at Stevens Hospital.) I understand that the revocation will not apply to information that has already been used or released in response to this authorization. I understand that any disclosure of information carries with it the potential for redisclosure and that the information may no longer be protected by privacy laws.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(Patient, Guardian\*, or Authorized Representative\*)  
(\*Please provide documents to prove authority to sign on behalf of the patient.)

This authorization will expire 90 days from the date signed or as indicated: Date of expiration or event resulting in expiration of authorization: \_\_\_\_\_

*Possible copying fee required*

This form is available at: <http://www.stevenshospital.org> (Patients & Visitors, Health Care Forms)

