Schick Shadel Hospital Closed effective 06/30/2022 UHS-NRO now handles all Release of Information Requests - Fax # 615-997-1200 Phone # 615-312-5834 1000 Health Park Dr. Bldg. 3 Ste. 400 Brentwood, TN 37027 - Email: nrorecordsrequests@uhsinc.com

SCHICK SHADEL HOSPITAL – 1210l Ambaum Blvd SW, Burien, WA 98146 – 206.244.8100

Patient Authorization for Disclosure of Health Information

Name: _____ Date of Birth_____/_____/_____
Address: _____ City: _____State: _____ Zip: _____
Phone: _____ Email or Fax# _____

I request that my protected health information (PHI) from Schick Shadel Hospital be disclosed to:

Recipient Name_____

Address: _____ City: _____ State: ___Zip: _____

Phone: _____Fax (healthcare provider only):_____

I authorize the following PHI to be released from my medical record(s): Intake Assessment ¨ Laboratory Report(s) ¨ X-Ray/EKG Report(s) ¨ Immunization Record ¨ Medical Record Summary (Includes Discharge Summary, History and Physical, Medications and Test Results)
Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol or Drug, or Substance Abuse Records¨ Yes ¨ No Dates: _____
HIV Testing and Results ¨ Yes ¨ No Dates: _____
Mental Health Records ¨ Yes ¨ No Dates: _____

Purpose for requesting information: ¨ Legal ¨ Insurance ¨ Personal ¨ Continuation of Care

_____

By signing this authorization form, I understand that: • I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Health Information Management Department at Schick Shadel Hospital. Revocation will not apply to information that has already been disclosed in response to this authorization. • Unless otherwise revoked, this authorization will expire in 90 days.

Patient Signature: _____ Date: _____

Print Name: _____ MR # _____