SWEDISH MEDICAL CENTER FOUNDATION

PRIVACY INFORMATION FOR ALL SUMMIT CLUB and FOUNDERS CIRCLE MEMBERS

The Health Insurance Portability and Accountability Act (HIPAA) sets a national standard for protecting personal health information. Healthcare providers must be in compliance with HIPAA's privacy rule. Washington State laws also provide for protection of personal health information. Swedish provides training for employees and volunteers to ensure patient privacy is protected.

The law affects those of us who are involved with the Swedish Medical Center Foundation, particularly when a donor requests a private room at the hospital. In order to obtain a private hospital room on the appropriate floor, we need to inquire as to the nature of your illness, the name of your doctor, and the approximate length of your stay in the hospital.

Sometimes this information is provided to us directly from you or we learn about your admission from the hospital. Each morning, when appropriately authorized, Foundation staff receive a copy of the names of Summit Club and Founders Circle members who are admitted into the hospital. If this report shows that you are not in a private room, the Foundation staff will take steps to make sure you are first on the waiting list for a private room.

Swedish Medical Center requires authorization from you in order to provide information about you and your hospital stay to the Foundation. It is important that you know the authorization you are providing is limited to the information we need to know to provide you with benefits. The Foundation staff will not be allowed access to your private medical records.

Please sign the Authorization for Disclosure of Health Information form below and return in the envelope enclosed. If you have any questions regarding this law please do not hesitate to call Jennifer T. Nolte, Gift Clubs & Annual Giving Coordinator at 206-386-2711.

SUMMIT CLUB/FOUNDERS CIRCLE AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name (please print) _____ Birth Date _____

Spouse or Partner
Name (please print) _____ Birth Date _____

Address _____ City _____ State/Zip _____

Daytime Phone _____ Email _____

I am a member of the Summit Club or Founders Circle. When I am a patient at Swedish Medical Center, I hereby authorize Swedish Medical Center to provide information about me, including the name of my attending physician, the type of care needed, and the number of days I am expected to be in the hospital, to Swedish Medical Center Foundation staff or Swedish VIP International Services. The purpose of the disclosure of this information is so the Foundation staff can request certain benefits of membership on my behalf, such as a private room for hospital stays at Swedish. I understand that I am not required to sign this authorization in order to receive healthcare treatment at Swedish Medical Center.

I understand that the Swedish Medical Center Foundation may contact me regarding contributions and support for Swedish Medical Center and that my information will be kept confidential.

This authorization expires when I am no longer a member of the Summit Club or Founders Circle, but it may be revoked in writing by me at any time, except to the extent that action has been taken in reliance on this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal or state confidentiality laws.

Signature _____ Date _____

Signature _____ Date _____