

Spokane Digestive Center 105 W. 8th Avenue, Suite 6010 Phone (509) 838-5950 Fax (509) 838-5961

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Last First MI Maiden or other name	Patien	t's Legal Name:						
I hearby request and authorize the release of medical records/information as indicated below for the above named patient: Send Records				Fi	rst	MI	Maiden or other name	
To/From: Dr's Cohen, Hong, Kestell, Houglum, Durnford, Stone, Goff (please circle) Chris Bell PA-C, Kristen Lee ARNP 105 West 8th Avenue, Suite 6010 Spokane, WA 99204-2341 Send Records To/From: (please circle) Medical Records/Information to be Released: Dates Consultations All health care information Lab reports Other: Other: Changing Physicians Legal Insurance Billing Genetic testing Consultation Authorization will expire 1 YEAR after I have signed the form. 1 I understand that this authorization will expire 1 YEAR after I have signed the form. 2. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient. 3. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Spokane Digestive Center in writing or by completing the Revocation of Authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Records Received By Date Relationship to Patient THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED For SDDC Use Only But Patient THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED	Date o			Last 4 Digits of SS#				
To/From: (please circle) Chris Bell PA-C, Kristen Lee ARRP 105 West 8th Avenue, Suite 6010 Spokane, WA 99204-2341		Mo	Day Year					
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Medical Records/Information to be Released: Dates Consultations	Send Records		•	Chris Bell PA-C, Krist 105 West 8 th Avenue	en Lee . , Suite 6	ARNP	Stone, Goff	
Consultations	Send 1	Records						
All health care information	Medical Records/Information to be Released: Dates				-	fically authorize the	release of information relating	
Purpose of Disclosure: Changing Physicians Legal Insurance Billing Other (please specify): 1. I understand that this authorization will expire 1 YEAR after I have signed the form. 2. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient. 3. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Spokane Digestive Center in writing or by completing the Revocation of Authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Or Signature of Patient Date Parent/Legal Guardian/Authorized Person Records Received By Date Relationship to Patient THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED For SDDC Use Only Date request filled		All health care Lab reports X-ray reports	e information			Mental health (Incl HIV related inform Genetic testing	luding psychotherapy notes) ation (AIDS related testing)	
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THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED For SDDC Use Only By:		Signature of Patient Da		æ	Parent/Legal Gu	ardian/Authorized Person		
For SDDC Use Only Date request filled By:		Records Received By Da		te	Relation	nship to Patient		
Date request filled	THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED							
Identification Presented Fee Collected: \$ (Rev 10/17)								
	Identification Presented					e Collected: \$	(Rev 10/17)	