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

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's Legal Name:_____ _____
Last First MI Maiden or other name

Date of Birth: _____ - _____ - _____ Last 4 Digits of SS# _____
Mo Day Year

I hearby request and authorize the release of medical records/information as indicated below for the above named patient:

Send Records **To/From:** (please circle) Dr's Cohen, Hong, Kestell, Houglum, Durnford, Stone, Goff
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	_____
☐ X-ray reports	_____
☐ Other:_____	_____
_____	

I specifically authorize the release of information relating to:

- ☐ **Substance abuse (including alcohol/drug abuse)**
- ☐ **Mental health (Including psychotherapy notes)**
- ☐ **HIV related information (AIDS related testing)**
- ☐ **Genetic testing**

_____ _____
Signature of patient or legal guardian **Date**

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 _____ By:_____
Identification Presented _____ Fee Collected: $_____ (Rev 10/17)