Spokane Digestive Center

105 W. 8th Avenue, Suite 6010

Phone (509) 838-5950

Fax (509) 838-5961

**AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION**

|  |  |
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| Patient’s Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First MI Maiden or other name  Date of Birth: \_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_ Last 4 Digits of SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mo Day Year  **I hereby request and authorize the release of medical records/information as indicated below for the above named patient:**  **Send Records To/From:** Spokane Digestive Center  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 1/20)  www.spokanedigestive.com | |