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 nameDate 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 OnlyDate request filled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Identification Presented \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fee Collected: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Rev 1/20)www.spokanedigestive.com |