

Authorization for Release of Information

Patient Information

Patient Name: _____

Patient DOB (mm/dd/yyyy): _____ Patient SSN: _____

Information to be released from: _____

Information to be sent to: Steve Bartel, Risk Manager
1033 W. Gardner
Spokane, WA 99260
(509) 477-6113

Information to be released

- All medical records (chart notes, admin records, tests, reports, correspondence, etc.)
- All medical bills and insurance billing.
- Specific information (Please specify: i.e. x-rays, etc.) _____

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (please initial):**

- _____ Drug/Alcohol abuse/treatment & diagnosis
- _____ Sexually Transmitted Disease
- _____ Mental Illness or Psychiatric diagnosis/treatment
- _____ HIV/AIDS diagnosis/treatment/testing

Patient Rights

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

Such release of the foregoing shall be authorized upon presentation of this authorization or any duplicate or photostatic copy of thereof.

This authorization will expire 90 days from the date signed.