PROVIDENCE
Spokane Heart Institute

Spokane Cardiology

Patient Authorization for Release of Protected Information

(1) NAME: _____ OTHER NAMES: _____
ADDRESS: _____
BIRTHDATE: _____ SSN: _____ PHONE: _____

(2) Records **FROM:**

Name: Kootenai Heart Clinics (Spokane Offices)

Address: 2003 Kootenai Health Way

Coeur d'Alene, ID83814

Phone: 208-625-6245 Fax: 208-625-6247

Records **TO:**

Name: Providence Spokane Cardiology

Address: 62 West 7th Ave Suite 450

Spokane, WA 99204

Phone: 509-455-8820 Fax: 509-838-4978

(3) Information to be disclosed:

***Dates of Service*:**

❒ Office Consultation Report — Last 2

❒ Cardiac Testing EKG, Echo, Stress Test, Monitors, — Most recent

❒ Other: Specify All surgeries, Latest Device Check — All

-OR-

❒ Last 4 years of Spokane Cardiology Records.

(4) Rights and Responsibilities. I consent to release of my records. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the doctors and staff from all legal responsibility or liability that may arise from the release of this information. I understand I do not have to sign this authorization in order to receive health care benefits. To revoke this authorization, I must give notice in writing, but I may not revoke release of information if its purpose is to obtain insurance or physician payment for services rendered. Once health care information is disclosed, the person or organization that receives it may re-disclose it for purposes of my care and/or payment for services.

(5) Signature _____ Relationship _____

Date _____ Print name if other than patient _____

Please return form to Spokane Cardiology by mail, fax, or email

Providence Spokane Cardiology
62 West 7th Ave, Suite 450
Spokane, WA 99204
Fax: 509-838-4978
WASCHealthInformationManagement@providence.org