

Patient Authorization for Release of Protected Information

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

<p>(2) Records FROM: <input type="checkbox"/> Spokane Cardiology <input type="checkbox"/> NW Heart & Lung <input type="checkbox"/> Vascular Institute</p> <p>OR: Name: _____ Address: _____ _____ Phone: _____ Fax: _____</p>	<p>Records TO: <input type="checkbox"/> Spokane Cardiology <input type="checkbox"/> NW Heart & Lung <input type="checkbox"/> Vascular Institute</p> <p>OR: Name: _____ <input type="checkbox"/> Patient <small>(same as listed above)</small> Address: _____ _____ Phone: _____ Fax: _____</p>
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(3) Information to be disclosed:

Dates of Service:

- Office Consultation Report
- Testing _____
- Other: Specify _____
- OR-**
- Last 1 year of records
- Last 4 years of 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 _____ **Date Signed** _____

*If a representative is signing on behalf of the patient, please fill out the following:

Relationship _____ Printed Name _____

If patient is not a minor, is Power of Attorney included? YES NO ALREADY ON FILE (circle one)

**** (6) (Optional) This authorization expires in 90 days from the date signed, unless indicated:**

On (date): _____ or, when the following event occurs: _____

****Please fill out form completely****

Return Instructions: Please drop off in person, by mail or email to: waschealthinformationmanagement@providence.org at least **2 weeks prior** to your visit with Spokane Cardiology