OB/GYN Associates of Spokane PS
601 W 5th Ave #301
Spokane WA 99204
Phone (509)455-8866 Fax (509)623-2555

Authorization to Release Health Care Information

Patient's Name _____ Date of Birth _____

SSN _____ Previous Name _____

Address _____ City _____State _____ Zip _____

Phone (day) _____ (evening) _____

FROM: **TO:**

Name _____ Name _____

Address _____ Address _____

City/State _____Zip_____ City/State_____Zip_____

I hereby authorize the above named physician or facility to release my medical records to the other above named physician or facility. I understand that the information disclosed may contain matter that is protected by Federal and state laws, including information which may relate to alcohol, drug, psychiatric treatment, AIDS and/or HIV testing and /or other sexually transmitted diseases. I specifically consent to release and disclosure of this information, unless indicated below.

- OR –

Information to be released	**Dates**	**Purpose of disclosure** (at my request)
___History and physical exam	_____	____Changing physicians
___Progress Notes	_____	____Continuing Care
___Lab reports	_____	____Legal
___X-Ray Reports	_____	____School
___Other	_____	____Insurance
_____		____Other _____

Please exclude _____
_____

Transmission method: Mail _____ Electronic _____

1. This authorization is valid for 90 days from the date it is signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has not already taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

Signature of patient or patient's authorized representative Date

_____

Relationship of authorized representative (patent, legal guardian, etc)