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Spokane WA 99207
Secure Email: tammy@nswomenshealth.com
(509)489-2101 Fax: (509)252-1561 or (509)483-2521

Authorization for the Use, Disclosure or Release Of Protected Health Information

Section 1 Patient Information **Provider:** **Acct #:**

Patient Name(printed)_____
LAST FIRST MI

Date of Birth: _____ Daytime phone:_____ Cell:_____

Address:_____Mailing if different:_____
Street City, St, Zip Street City, St, Zip

Section 2 Information to be *released by*: (Person/Organization providing the information)

Name of Office/Facility:_____ Attn:_____

Address:_____
Street City, St, Zip

Phone Number: ( )_____ Fax: ( )_____

Section 3 Information to be *released to*: (Person/Organization receiving the information)

Name of Recipient:_____ Attn:_____

Address:_____
Street City, St, Zip

Phone Number: ( )_____ Fax: ( )_____

Section 4 Information requested: (Please select only one)

☐ **Most recent 2 years** of relevant information (visit notes, lab results, radiology, pathology, operative and procedure notes)
☐ Specific information (please specify, i.e. pap, mammogram, etc)_____

Section 5 Purpose for which the disclosure is being made: (Please select only one)

☐ Legal ☐ Insurance ☐ Continuity of Care ☐ Personal Use ☐ Military

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and/or HIV status.

I understand and agree that unless I specify otherwise, all medical information including the diagnoses and treatments described above may be released.

Please initial this statement if you do NOT authorize the release of the information described above. ☐ ***I do NOT authorize the release of the information listed above.***

- **I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.**
- **I understand that North Spokane Women's Health will not deny treatment or payment based upon whether I sign this authorization.**
- **I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.**
- **I understand that I am entitled to a copy of this authorization after I sign it.**

Signature of patient/legal representative:_____ Date:_____

Relationship to patient, if other than patient:_____

Signature of witness if applicable:_____ Date:_____

There will be a charge for copies of your medical record unless the copies are being sent to another healthcare provider/facility.

This authorization will expire 60 days from the date signed.