OB/GYN Associates of Spokane PS
601 W 5th Ave #301
Spokane WA 99204
Phone (509) 455-8866 Fax (509) 455-3413

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 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 sexually transmitted diseases. I specifically consent to release and disclosure of this information as indicated below:

Information to be released	**Dates**	**Purpose of Disclosure**
__ 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 day 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 (parent, legal guardian,etc)