AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

PATIENT: D.O.B:

Information to be released from: Valley Gastroenterology
(Name of Facility)

12401 E Sinto Avenue, Spokane, Wa, 99216
(Address)

(509) 922-2055 (Phone Number)
(509) 922-2307 (Fax Number)

Information to be released to:

NAME:___________________________________ RELATION:___________________________

NAME:___________________________________ RELATION: ____________________________

NAME:___________________________________ RELATION: ____________________________

Information to be released:

☐ The most recent 2 years of pertinent information (chart notes, labs, x-ray and special tests)
☒ All medical records
☐ Specific information (Please specify):____
____

Purpose for which disclosure is being made: (Please check one of the following)

☐ Attorney ☐ Insurance ☐ Doctor ☒ Personal

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give specific authorization for these records to be released.

*EXCLUDE the following information from the records release (please initial):
________Drug/Alcohol abuse/treatment & diagnosis ________Sexually Transmitted Disease
________HIV/AIDS diagnosis/treatment/testing ________Mental Illness or Psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing (to view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: ____ **Date:** ______________
(Patient, Guardian*, or Authorized Representative*)
[*please provide document to prove authority to sign on behalf of the patient]

This authorization will expire one year from the date signed.
Possible copying fee required