



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

PO Box 3649
Spokane, WA 99220-3749
(509) 838-2531 • Fax (509) 342-3962

Section 1 Patient Information:

Patient Name: _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____ Phone Number :(____) _____
Month Day Year

Address: _____
Street City State Zip Code

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

Name of Office/Facility: _____

Address: _____
Street City State Zip Code

Phone Number: (____) _____ Fax Number :(____) _____

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

Name of Recipient: _____

Address: _____
Street City State Zip Code

Phone Number: (____) _____ Fax Number :(____) _____

Section 4 Information Requested: (Please select one)

- Most recent 2 years of relevant information (visit notes, lab results, radiology findings, pathology reports, operative, and procedure notes)
- Specific information (please specify, i.e. immunization records) _____
- All medical records

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

- Legal
- Insurance
- Ongoing Care
- Personal Use

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 the information, if any, pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES
(You must initial one)

I do ____ do not ____ authorize this information to be released.

Limitations, if any: _____

- 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 Rockwood Clinic, P.S. 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 physician or healthcare facility.

This authorization will expire one (1) year from the date signed.