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## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**I hereby authorize** \_\_\_\_\_

to disclose the following information from the health records of:

Patient Name: \_\_\_\_\_ (Last, First, Middle)

Previous Name: \_\_\_\_\_ (Last, First, Middle)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) - Social Security Number - -

Birth date: \_\_\_\_\_ Dates of Medical Care \_\_\_\_\_

**To be disclosed to:** \_\_\_\_\_ (Name)

\_\_\_\_\_ (Attention)

\_\_\_\_\_ (Address)

\_\_\_\_\_ (City, State, Zip)

( ) - (Telephone) ( ) - (Fax)

**Information to be disclosed:**

- |  |   |
|--|---|
| <input type="checkbox"/> History & Physical                    | <input type="checkbox"/> Progress (Chart) Notes |
| <input type="checkbox"/> Discharge Summary                     | <input type="checkbox"/> Operative Report       |
| <input type="checkbox"/> Diagnostic Studies (Labs, X-Ray, EKG) | <input type="checkbox"/> Other _____            |

**For the purpose of:** \_\_\_\_\_

I understand that this authorization, unless expressly stated by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions.

I understand that 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 any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment at Surgical Specialists of Spokane.

**Expiration date or event** \_\_\_\_\_ \*

\*Authorization for disclosure to a financial institution or employer of the patient for purposes other than payment for healthcare services expires 90 days after date signed.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_ **Date:** \_\_\_\_\_