Spokane Valley Ear, Nose & Throat and Facial Plastics

Ph. 509-928-7272 Fax 509-928-7346

Authorization for Release of Information

Failure to complete this form in its entirety will cause a delay in releasing records

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____ PREVIOUS/OTHER NAME: _____

MY AUTHORIZATION

You may use or disclose the following health care information: (check all that apply)

- ☐ All health care information in my medical record.
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., x-rays, bills), specify date(s): _____

Please EXCLUDE the following information from the records release: (check all that apply)

- ☐ HIV (AIDS virus)
- ☐ Psychiatric disorders/ mental health
- ☐ Sexually transmitted diseases
- ☐ Drug and/or alcohol use

Records may be released FROM: Spokane Valley Ear, Nose & Throat and Facial Plastics
Address: 1424 N McDonald, Ste 101 City: Spokane State: WA Zip: 99216 Phone: 509-928-7272

Records may be released TO: _____ Phone/fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization: _____

This authorization will be good until:

- ☐ This date: _____
- ☐ When the following occurs: _____
- ☐ In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

Minors: A minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age is 14+), HIV/ AIDS (if age is 14+), drug and/or alcohol abuse (if age is 13+), and mental health or illness (if age is 13+).

Minor Signature if applicable: _____ Date: _____

MY RIGHTS

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form to 1) receive research-related treatment in connection with research studies or 2) receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing at any time.. If I do, it will not affect any actions taken by Spokane Valley Ear, Nose & Throat in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: 1) Fill out a revocation form – a form is available from Spokane Valley Ear, Nose & Throat or 2) Write a letter to Spokane Valley Ear, Nose & Throat.
- **Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.**

Additional Note:
I understand that the first copy of records released from our office will be released free of charge. Each additional copy of records after that will be available at $20 per copy.

_____ _____
Signature of PATIENT / Parent/ Legal Guardian/Authorized Person DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

Release expires: _____

Revised 10-04-13