AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RECORDS TO BE RELEASED FROM / TO (Circle One)

Columbia Surgical Specialists
Medical Records
217 W Cataldo
Spokane WA 99201
Phone (509) 323-5409 | Fax (509) 329-5839

I request and authorize you to furnish records for the purpose of: _____, or at my request.

Information to be released:

- ☐ All medical records, including all clinical, hospital, or billing records in full.
- ☐ Medical records, including all clinical, hospital, or billing records from the past _____ year(s).
- ☐ Other specific information as listed here: _____

_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), sexually transmitted diseases, drug and/or alcohol abuse, and psychiatric disorders/mental health. I give my specific authorization for the release of records that may contain this information unless otherwise stated here: _____.

RECORDS TO BE SENT TO / FROM (Circle One)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone and Fax: _____

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I understand that:

1. I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, enrollment, or eligibility).
2. I may revoke this authorization in writing at any time, except to the extent that action has been taken based upon it. Even if I do not revoke it, this authorization expires 90 days from the date signed.
3. The recipient of these records may further disclose this information and it may no longer be protected by federal privacy regulations.
4. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4)(HIPAA).
5. I am entitled to a copy of this document.
6. A copy of this authorization is as valid as the original.

_____ _____

Signature of Patient or Patient Representative Date

_____

Description of Representative's Authority to Act for Patient (e.g., Parent, Guardian, Legal POA)