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 he All health care information in my medical record. Health care information in my medical record relat Health care information in my medical record for t Other (e.g., x-rays, bills), specify date(s):	ring to the following treatme	nt or condition:	
Please EXCLUDE the following informa			
☐ HIV (AIDS virus)	☐ Sexually transmitted diseases		
☐ Psychiatric disorders/ mental health	□ Drug and/or alcohol use		
Records may be released FROM: Spokane Va			
Records may be released TO:		Phone/fax:	
Address:	City:	State:	Zip:
☐ This date: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	financial institution or an emplo	ed to reproductive care, sexual	her than payment) ly transmitted diseases (i
Minor Signature if applicable:		Date:	
I understand that I do not have to sign this authorization benefits). However, I do have to sign an authorization receive health care when the purpose is to create heal I may revoke this authorization in writing at any time reliance on this authorization before it receives my wrinsurance. Two ways to revoke this authorization are Throat or 2) Write a letter to Spokane Valley Ear, No. Protection after Disclosure. I understand that on may re-disclose it and that privacy laws may no letter.	on form to 1) receive research-relate care information for a third partitle in the care information for a third partitle in the care information. I may not be set 1) Fill out a revocation formation to the care information formation formation formation formation formation formation formation formation.	elated treatment in connection wit party. ctions taken by Spokane Valley Ea able to revoke this authorization - a form is available from Spokane	th research studies or 2) ar, Nose & Throat in if its purpose was to obtain c Valley Ear, Nose &
Additional Note: 1 understand that the first copy of records released from our of available at \$20 per copy.	fice will be released free of char	rge. Each additional copy of recor	rds after that will be
Signature of PATIENT / Parent/ Legal Guardian/	Authorized Person	DATE	
RECORDS RECEIVED BY DATE	RELATIONSHIP	TO PATIENT	
Release expires:			