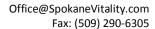


## Authorization for the Use, Disclosure or Release of Protected Health Information

Office@SpokaneVitality.com Fax: (509) 290-6305

Section 1. Patient Info: Patient's Full Name: Date of Birth: \_\_\_/\_\_\_ SS #: \_\_\_\_\_ Phone #: (\_\_\_\_\_) Section 2. Information to be released by: (Person/Clinic in possession of medical info) Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_ Section 3. Information to be received by: Address: Phone #: (\_\_\_\_\_) \_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_ **Section 4. Information requested:** (Please select one) Most recent one (1) year of relevant information (lab results, prescription notes, visit notes) Specific information (please specify, i.e. "lab results") All medical records Section 5. Purpose for which the disclosure is being made: (Please select one) Transfer of Care Ongoing Care \_\_lLegal Insurance 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*: I do \_\_\_\_\_ do not\_\_\_\_ authorize this information to be released. Limitations if any:





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

- 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 in Section 3 and may no longer be protected by federal privacy regulations
- I understand that Spokane Vitality Center, 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 already 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: | <br> | <br> |
|-----------------------|------|------|
|                       |      |      |
| Date:                 |      |      |

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