Spokane Orthopedics Authorization

Release of Health Care Information

Phone: (509) 489-2851 Fax: (509) 484-0103

Patient's name: ____ Date of birth: __________________

SSN: ________________________ Previous name: ____________________________________

I request and authorize SPOKANE ORTHOPEDICS to release health care information of the patient named above to:

Name: ____________________________________ ____
Institutional Affiliation

Address: ____

City, State: ____ Zip Code: ____________________

This request and authorization applies to:

______ Health care information relating to the following treatment, condition, or dates of treatment.
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______ All health care information.

______ Other: ____

I understand that my consent includes the release of any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health, or drug and/or alcohol use in our possession. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

____ ____________________
Signature of patient or patient's authorized representative Date signed

____ ____________________
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.) Date signed

Additional signature required if requesting records from outside facilities that are maintained in our office.

____ ____________________
Signature Date signed