PROVIDENCE Spokane Heart Institute

Providence Spokane Cardiology
122 W. 7th Ave, Suite 450
Spokane, WA 99204
Fax 509-838-4978

Providence NW Heart & Lung
122 W. 7th Ave, Suite 110
Spokane, WA 99204
Fax 509-625-1868

Providence Vascular Institute
122 W. 7th Ave, Suite 410
Spokane, WA 99204
Fax 509-626-9475

Patient Authorization for Release of Protected Information

(1) NAME: _____ OTHER NAMES: _____
ADDRESS: _____
BIRTHDATE: _____ SSN: _____ PHONE: _____

(2) Records FROM: ☐ Spokane Cardiology ☐ NW Heart & Lung ☐ Vascular Institute

OR:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Records TO: ☐ Spokane Cardiology ☐ NW Heart & Lung ☐ Vascular Institute

OR:
Name: _____ ☐ **Patient** (same as listed above)
Address: _____
_____
Phone: _____ Fax: _____

(3) Information to be disclosed:

***Dates of Service*:**

❒ Office Consultation Report _____
❒ Testing _____ _____
❒ Other: Specify _____ _____

-OR-

❒ Last 1 year of records
❒ Last 4 years of records

(4) Rights and Responsibilities. I consent to release of my records. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the doctors and staff from all legal responsibility or liability that may arise from the release of this information. I understand I do not have to sign this authorization in order to receive health care benefits. To revoke this authorization, I must give notice in writing, but I may not revoke release of information if its purpose is to obtain insurance or physician payment for services rendered. Once health care information is disclosed, the person or organization that receives it may re-disclose it for purposes of my care and/or payment for services.

(5) Signature _____ Date Signed _____

*If a representative is signing on behalf of the patient, please fill out the following:

Relationship _____ Printed Name _____

If patient is not a minor, is Power of Attorney included? YES NO ALREADY ON FILE (circle one)

**** (6) (Optional) This authorization expires in 90 days from the date signed**, unless indicated:
On (date): _____ or, when the following event occurs: _____

Please fill out form completely