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PAIN CLINIC OF SPOKANE

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MEDICAL RECORDS RELEASE

Patient Date of Birth: _____ Patient SSN: _____-_____-_____

I, _____, hereby consent to the release of my medical records.

I understand my records will be released TO / FROM:

Person/Entity _____

Address _____

Phone Number/Fax Number _____/_____

Records that will be released are: (please check all that apply)

_____ Notes for all dates of service in our office
_____ Notes for a specific date of service:

I understand and acknowledge that if none of the above options are checked, then my complete record will be disclosed. This authorization will expire one (1) year from the date it is signed, unless revoked earlier by me in writing.

Specific Authorization for HIV/AIDS Testing, Drug and Alcohol, and Mental Health Records:

I acknowledge that the records to be released MAY include material that is protected by Federal Regulation 42 CFR, part 2 and is applicable to the above. My signature below authorizes the release of all information. Check here to suppress disclosure of this type of information: [ ]

I hereby acknowledge the above information and authorize the release of said medical records and/or billing information to the above referenced person/entity. I understand that these records are protected by law and cannot be disclosed without my permission.

_____ _____

Signature of Patient (or other responsible party) Date