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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. I understand that this authorization will remain in force until revoked 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