SPOKANE VITALITY CENTER

# 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 #: (_____) _____

Address: _____

**Section 2. Information to be released by: (**Person/Clinic in possession of medical info)

Name: _____

Address: _____

Phone #: (_____) _____ Fax #: (_____) _____

**Section 3. Information to be received by:**

Name: _____

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)

☐ Legal ☐ Insurance ☐ Ongoing Care ☐ Transfer of Care ☐ 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:_____

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# 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: _____

Date: _____

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