

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.

_____ 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