Phone - (509) 270-0065 Fax – (509) 319-2520

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Healthcare Provider/Clinic: _____ Fax: _____

Address: _____

I request and authorize release of information of the patient named above to:

Mt. Spokane Pediatrics ~ 759 E Holland Ave, Spokane WA 99218
Mt. Spokane Pediatrics Valley ~ 1301 N Pines Rd, Spokane Valley WA 99206

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Other: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/Aids testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I hereby consent to the release of the above information. I understand that such information cannot be released without my informed consent. I understand that I may revoke this authorization at any time by notifying Mt. Spokane Pediatrics in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

YOUR SIGNATURE BELOW CONFIRMS THAT YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED.

_____ _____ _____

Signature of patient or legal guardian Relationship to patient Date

This Authorization expires 90 days from date signed unless indicated: Expires on (date/event):_____

**If the patient is a minor but is authorized to consent to health care without parental consent under federal and state law (age 13 and above for drug and alcohol information; age 14 and above for sexually transmitted disease information, including HIV/AIDS: and age 13 for mental health information only the patient shall sign this authorization form.*