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**APPT DATE:** \_\_\_\_\_

**SIM Chart#** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**Please send all records in a PDF electronic format on a media CD by mail or email**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last 4 of SSN# \_\_\_\_\_ Phone # \_\_\_\_\_

Information released <input type="checkbox"/> to <input type="checkbox"/> from (please check)  Previous Dr's Name: _____  Name of Facility: _____  Phone (____) _____  Fax (____) _____	Information released <input type="checkbox"/> to <input type="checkbox"/> from (please check)  <b>Spokane Internal Medicine</b> 1215 N McDonald Road Spokane, WA 99216 509-924-1950 <b>Email: medicalrecords@spokaneim.com</b>
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Purpose for release of information (Please check one):  Attorney  Insurance  Doctor  Personal  
 Transfer of care  Other \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- The most recent 2 years of pertinent information (Chart notes, labs, x-rays and special tests)
- All medical records
- Specific information (Please specify) \_\_\_\_\_

**PATIENT AUTHORIZATION:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

**EXCLUDE** the following information from the records released (please initial):

\_\_\_\_\_ Drug/Alcohol abuse/treatment & diagnosis      \_\_\_\_\_ Sexually Transmitted Disease  
 \_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_\_ Mental Illness or Psychiatric diagnosis/treatment

**MY RIGHTS:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted in the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand that this authorization will expire in 90 days after I have signed this form, unless otherwise stipulated. I understand that in compliance with Washington state statute, I will pay a fee of \$20 clerical fee for search and handling of records. Copying fee of \$ 0.88 per page first 30 pages and \$0.67 per page thereafter. There is no charge for medical records if copies are sent to medical facilities for ongoing care or followup treatment.

I hereby authorize the release of the medical records specified above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient responsible party authorizing release information.