GREGORY J. DOERING, M.D.
ANDREW E. CHESTER, M.D.
BRIAN T. YATES, M.D.
DAVID W. FISCHER, M.D.
INGRID LINTMAER, M.D.
ALAN J. KELLY, M.D.
JOHN D. SESTERO, M.D.
MICHAEL C. KERKERING, M.D.
ROBERT I. HUSTRULID, M.D.
KRISTINA K. SWIGGUM, M.D.
LYNN A. KOHLMEIER, M.D.
KRISTINA A. BOWEN, M.D.

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 ☐ to ☐ from (please check)	Information released ☐ to ☐ from (please check)
Previous Dr's Name:_____	Spokane Internal Medicine
Name of Facility:_____	1215 N McDonald Road
_____	Spokane, WA 99216
Phone (_____) _____	509-924-1950
Fax (_____) _____	**Email: medicalrecords@spokaneim.com**

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. 11/16