AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Doctors' Clinic

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Joe Campbell, PA-C
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PATIENT INFORMATION

Patient Name: _____
(Last) (First) (MI) (Maiden)

Date of Birth: / / Social Security# ____ ___ _____ Phone#( ) -

Information to be released from:	Information to be sent to:
Name: **The Doctors' Clinic**	Name:
Address: **220 E. Rowan, Ste 300**	Address:
City/State **Spokane, WA** Zip: **99207**	City/State: Zip:
Phone: **(509) 489-3554** Fax: **(509) 489-3558**	Phone: **( )** Fax: **( )**

Information to be released:

☐ The last two years of medical records. (To include chart notes, lab reports, x-rays and special tests)

☐ Pertinent information (as specified above) during the following dates:

From: _____ To: _____

☐ Other specific information.

Patient Authorization

I understand that my records may contain health information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drugs and /or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released and I understand that once the health information I have authorized to be disclosed reaches the noted recipient, the person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

I have the right to revoke this authorization by sending a notice stopping this authorization to the releasing address above. The authorization will stop on the date my request is received.

I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. (Request will not be processed without signature and date).

I understand I have the right to receive a copy of this authorization.

Signature: _____Date: _____/_____/_____
(Patient, Guardian or Authorized Representative) (Not valid after 1 year)