105 West Eighth, Suite 6020
Spokane, WA 99204
509.455.5050 **P**
509.624.5034 **F**
inlandobgyn.com

Authorization to Release Health Care Information

Patient's Name_____ Date of Birth_____

SSN_____ Previous Name_____

Daytime Phone _____ Date records needed by_____

I request and authorize:	**to release healthcare information as indicated below to:**
INLAND OBGYN 105 WEST 8TH AVE., STE. 6020 SPOKANE, WA 99204 (509) 455-5050 FAX (509) 624-5034 or (509) 207-4007	Name _____ Address _____ _____ Phone__(____)_____ Fax____(____)_____

Please check which request applies:

One (1) year of complete OB/GYN medical records ☐ **including** ☐ **excluding** any sensitive information regarding sexually transmitted disease, reproductive health, drug and alcohol history, mental health/physical abuse and HIV/AIDS information.

Or :

Specific information as follows ☐ **including** ☐ **excluding** any sensitive information regarding sexually transmitted disease, reproductive health, drug and alcohol history, mental health/physical abuse and HIV/AIDS information: _____

Purpose of disclosure: ☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care
☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation
☐ Other (please specify):_____

If I am requesting copies of my medical records for personal use, **I understand that in accordance with Washington Statute the following fee schedule will apply**: $1.12 per page for the first 30 pages; plus $.84 per page for all other pages. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment. Identification may be required before releasing information.

☐ Check here if you want the information in electronic format.

Consent of a minor: A minor patient's signature alone is required in order to release information concerning care for: (1) conditions relating to the minor's sexuality including, but not limited to reproductive health, sexually transmitted diseases (age 14 and above), (2) alcoholism and/or drug abuse (age 13 and above), (3) mental health conditions (age 13 and above).

_____
Signature of Minor Patient Date signed

_____
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.)

This authorization expires **90 days** after the date it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.