Selkirk Neurology
610 S Sherman Suite 201
Phone (509) 473-0885
Fax (509) 795-0895

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's Legal Name:____ ______________
Last First MI Maiden or other name

Date of Birth: _____ - _____ - _____ Last 4 Digits of SS# ____________
Mo Day Year

I hereby request and authorize the release of medical records/information as indicated below for the above named patient:

Send Records **To/From:** (please circle) Selkirk Neurology
610 S Sherman Suite 201
Spokane, WA 99202

Send Records **To/From:** (please circle) ______________________________
____
____

Fax: ______________________________

Medical Records/Information to be Released:

	Dates
☐ Consultations	____________
☐ All health care information	____________
☐ Lab reports	____________
☐ Imaging Reports	____________
☐ Other:__________	____________

I specifically authorize the release of information relating to:

- ☐ **Substance abuse (including alcohol/drug abuse)**
- ☐ **Mental health (Including psychotherapy notes)**
- ☐ **HIV related information (AIDS related testing)**
- ☐ **Genetic testing**

______________________________ __________
Signature of patient or legal guardian **Date**

Purpose of Disclosure: ☐ Changing Physicians ☐ Legal ☐ Insurance Billing ☐ Other (please specify):

1. I understand that this authorization will expire 1 YEAR after I have signed the form.
2. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient.
3. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Selkirk Neurology in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

______________________________ __________ or ______________________________
Signature of Patient Date Parent/Legal Guardian/Authorized Person

______________________________ __________ ______________________________
Records Received By Date Relationship to Patient

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED

For Selkirk Neurology Use Only

Date request filled ______________________ By:______________________________

(Rev 6/21)