AUTHORIZATION TO OBTAIN MEDICAL RECORDS

FROM ANOTHER MEDICAL PROVIDER

Patient Name: _____
Date of Birth: ____ /____/_____ Maiden or Other Name Used: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/work phone: _____

I hereby authorize the provider indicated below to release information from my medical record:

Name of Provider/Medical Group: _____
Phone: _____ Fax: _____
Address: _____

To: KM Plastic Surgery **324 S. Sherman St. Spokane WA 99202**
Phone: 509-315-4415
Fax: 509-315-8204

Information to be Released:

□ Entire Medical Record □ Lab Results □ X-Rays / Imaging Study □ Operative Report(s)
□ Entire Medical Record for Date(s) _____
□ Records for the following condition(s): _____
□ Other: _____

Purpose of Disclosure:

□ Changing Physicians □ Consultation / Second Opinion □ Insurance □Continuing Care
□ Legal □ School □ Other: _____

I hereby authorize KM Plastic Surgery to disclose my protected health information as described above. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information as described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.
I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient Signature: _____ Date: _____
Signature of Authorized Representative: _____
Printed Name: _____ Relationship to Patient: _____