SEATTLE NEURO
AND SPINE SURGERY
801 Broadway • Suite 617
Seattle, WA 98122
T 206.623.0922 F 206.623.1588

IMPORTANT - PLEASE READ
Copy Fee for Patient Requests
☐ <10 pages - FREE
☐ 10-30 pages - $20.00
☐ >30 pages - $40.00

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I give Seattle Neuro and Spine Surgery permission to ☐ release to ☐ obtain from:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

THE MEDICAL RECORDS OF

Last Name: _____ First Name: _____ Middle/Maiden: _____

Address: _____

Date of Birth: _____ Medical Record #: _____

Contact #: _____

CONTAINING THE FOLLOWING INFORMATION (Specify dates)

☐ All Medical Records _____ ☐ Discharge Summary _____

☐ ER Records _____ ☐ Operative Report _____

☐ Lab/EKG _____ ☐ Imaging _____

☐ History & Physical _____ ☐ Other: _____

I understand my records may contain information regarding diagnosis or treatment of substance abuse, communicable diseases including HIV/AIDS, or mental/psychiatric illness. I give my specific authorization for these records to be released:

☐ Mental health/psychiatric records ☐ Substance abuse records ☐ Communicable disease records ☐ None

For the purpose of: ☐ Continued care ☐ Attorney ☐ Personal ☐ Other: _____

PATIENT RIGHTS: I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Please see the **Proliance Surgeons Notice of Privacy Practices** for a description of how you may revoke this authorization.

Release of information authorized herein may result in the waiver by the patient of certain legal rights, including the protection of the physician/patient privilege.

REDISCLOSURE PROHIBITED: I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer be protected under Privacy laws.

The hospital may not condition treatment, payment, enrollment or eligibility for benefits on whether the patient signs this authorization.

Signature of Patient or Legally Responsible Party (A minor patient's signature may be required)	**Authority to sign, if not Patient**	**Date** (MO/DAY/YR)

This authorization expires 90 days from the date signed or on the following day/event: _____

You may be charged a fee for processing and copying of your medical records in compliance with the Washington State Uniform Health Care Information Act, RCW 70.02 section 102 (12), and an authorization does NOT have to be honored until the fees are paid.