MAIN OFFICE
Providence Heart
& Vascular Institute
122 W 7th Avenue
Suite 310
Spokane, WA 99204
509-838-7711
Fax 509-747-4664

NORTHSIDE
Central Medical Office Bldg
212 E Central Avenue
Suite 240
Spokane WA 99208
509-489-7504
Fax 509-482-9011

WALLA WALLA
St. Mary Medical Center
401 W Poplar
Cardiology Suite
Walla Walla, WA 99362
509-522-5731
Fax 509-522-5747

COEUR D'ALENE
700 Ironwood Drive
Suite 350
Coeur d'Alene, ID 83814
208-676-9913
Fax 208-666-0885

SANDPOINT
606 N 3rd Avenue
Suite 203
Sandpoint, ID 83864
208-263-2505
Fax 208-263-2908

Form #038

HEART CLINICS NORTHWEST
AUTHORIZATION TO USE OR DISCLOSE
HEALTH CARE INFORMATION

Patient name: _____

Date of birth: _____ Account#: _____

I hereby authorize _____ (print name of provider) to release information from my medical record as indicated below to:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED:

	Dates		Dates
❑ Office visit / Progress notes	_____	❑ Echo reports	_____
❑ Lab reports	_____	❑ EKG reports	_____
❑ Treadmill / Stress tests	_____		

Other: _____

I specifically **DO NOT** authorize the release of information for categories checked below:

❑ Substance abuse (including alcohol/drug abuse) ❑ Mental health
❑ Sexually transmitted diseases ❑ HIV related information (AIDS related testing)

PURPOSE OF DISCLOSURE:

❑ Medical treatment ❑ Legal ❑ Insurance ❑ Personal ❑ Disability Determination

Other (please specify): _____

This authorization ends 90 days from the date signed unless indicated below (if disclosure is to a financial institution or an employer of the patient for purposes other than payment):

❑ on (date): _____
❑ when the following event occurs: _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I did, it would not affect any actions already taken by Heart Clinics Northwest based upon this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it, and privacy laws may no longer protect it. By authorizing the release of this information, I understand that my health care and payment for my healthcare will not be affected.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of patient Relationship
(parent, legal guardian, personal representative)