NORTHWEST
SPINE & PAIN MEDICINE

Patient Information:

Patient Name_____ Date of Birth:_____
Previous Name:_____ Phone Number:_____
READY TO BILL/BG/NWSPM

Information to be released by: (Person/Organization providing the information)

Name of Office/Facility: Attn:_____
Address:_____
Phone Number:_____Fax Number: _____(_____

Information to be released to: (Person/Organization receiving the information)

Name of Office/Facility:_____ Attn:_____
Address:_____
Phone Number:_____Fax Number: _____

Information Requested: (Please select one)

- ☐ Most recent 2 years of relevant information (visit notes, lab results, radiology findings, pathology reports, operative, and procedure notes)
- ☐ Specific information (please specify, i.e. visit notes only) _____
- ☐ All medical records

Purpose for which the disclosure is being made: (Please select one)

☐ Legal ☐ Insurance ☐ Continuity of Care
☐ Personal Use ☐ Military

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, sexually transmitted diseases (STDs), acquired immune deficiency syndrome (AIDS), and/or HIV Status.**

I understand and agree that unless I specify otherwise, all medical information including the diagnoses and treatments described above may be released.

Please initial this statement if you do **not** authorize The release of the information described above. ☐ I do **not** authorize the release of the information listed above.

- I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that Inland Neurosurgery and Spine Associates will not deny treatment or payment based upon whether I sign this authorization.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- I understand that I am entitled to a copy of this authorization after I sign it.

Patient or legally authorized individual signature Date Time

South Hill
3124 S. Regal St.
Spokane, WA 99223

Ph. 509.464.6208

CDA
509 W. Hanley Ave. Suite 101
Coeur D' Alene, ID 83814

Fx. 888.316.1928

North Office
9425 N Nevada St. Suite 300
Spokane, WA 99218

northwestspineandpain.com