Authorization for **Valley Obstetrics & Gynecology, P.S.** to Use or Disclose My Health Care Information
1415 N. Houk, Suite A Spokane, WA 99216-1305 Phone: (509) 924-1990 Fax: (509) 232-3059

Patient Information:

Patient Name: ____**Previous Name(s):**______________________________

Date of Birth: ______/______/________ **Phone Number:** (______) ______-________

Month Day Year

Records/Information Requested from: (Organization providing the information)

Name of Office/Provider: ____

Address: ____

Street City State Zip Code

Phone Number: (______) ______-________ **Fax Number:** (______) ______-________

Records/Information Requested to: (Person/Organization receiving the information)

Name of Recipient/Organization: ____

Address: ____

Street City State Zip Code

Phone Number: (______) ______-________ **Fax Number:** (______) ______-________

Section 4 Information Requested: (Please select one)

___ **All health care information in my record**
___ **Health care information in my medical record relating to the following treatment/condition:** ___________________________
___ **Health care information in my medical record for the date(s):** ____
___ **Other (i.e. x-rays, bills, etc) specify date(s):** ____

Section 5 Requested format: (Please select one)

___ **Fax** ___ **Mail** ___ **Pick Up**

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 disease (STD), acquired immune deficiency syndrome (AIDS), and/or HIV status. I under-stand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be used or disclosed.

PLEASE INITIAL THE STATEMENT THAT APPLIES (You must initial one)

_____ I **do** authorize this information to be released. _____ **I do not** authorize this information to be released

Section 6 Purpose for which the disclosure is being made: (Please select one)

____ **Legal** ____ **Insurance** ____**Ongoing Care** ____ **Personal Use**

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 **Valley Obstetrics & Gynecology, P.S.** 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. **This authorization will expire in 90 days from the date signed.**

Signature of patient or legally authorized individual: ____ Date: ___________________

Printed name if signed on behalf of the patient: ____

There will be a charge for copies of your medical record unless the copies are being sent to another physician or healthcare facility

Dear Valued Patient:

It is the policy of Valley OBGYN to provide courtesy copies of your medical records to health care providers outside the clinic who may be participating in your care. These copies are provided at no cost.

If, however, copies are requested for personal reasons, and they are not required for continuity of care, a processing fee is typically charged. As a courtesy to Valley OBGYN patients, our fees for medical record copies are below the rates allowable under Washington state law. Pre-payment may be required prior to copying medical records in those cases where a significant number of pages (31 or more) are requested. There is also a $28.00 clerical fee charged (per each request) in addition to the per page charges.

Fee Structure for Medical Record Copies

Pages	Fee
Pages 1-30	$1.24 per page
Pages 31 or more	$0.94 per page
Shipping	Actual Cost
Sales tax	8.9% to be included

In order to release your medical records for any reason other than treatment, payment or health care operations, we must have a completed authorization form. Valley OBGYN's **Authorization to Release Medical Records** form may be downloaded by clicking this link www.valobgyn.com or may be picked up at our location.

The process for obtaining copies of your medical records is relatively easy. As soon as we have received your completed **Authorization to Release Medical Records** form, a fee quote will be mailed, faxed, or phoned to you. The quote will include further instructions for payment and will also provide contact information in case you have questions. **Unsigned or incomplete authorization forms cannot be processed.**

In order to make it convenient for you, we have provided you with three options for returning your completed authorization form:

1. You may fax it to: (509) 232-3059
2. You may personally return it to our office:
   Valley OBGYN
   1415 N. Houk, Ste A
   Spokane Valley, WA 99216

   1334 N. Whitman Ln, Ste 220
   Liberty Lake, WA 99019
3. You may mail it to our office:
   Valley OBGYN
   1415 N. Houk, Ste A
   Spokane Valley, WA 99216

   1334 N. Whitman Ln, Ste 220
   Liberty Lake, WA 99019

As a Valley OBGYN patient, you are important to us. Please feel free to contact us at (509) 924-1990, if you have any questions or would like additional information.

Thank you!

Valley OBGYN