



**EMERGENCY RESPONDERS  
HEALTH CENTER**

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1330 N. Washington St. Suite 1080 • Spokane, WA 99201 • Phone: (509) 824-7327 • Fax: (509) 824-7317

**AUTHORIZATION TO RELEASE HEALTH INFORMATION AND/OR MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I authorize:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**To release health information of the patient above to:**

**Emergency Responders Health Center**  
1330 N. Washington St. Suite 1080  
Spokane, WA 99201  
Phone: (509) 824-7327 Fax: (509) 824-7317

Include health information from the following dates: \_\_\_\_\_ to \_\_\_\_\_

**Type(s) of health information to be included:**

- |   |   |
|---|---|
| <input type="checkbox"/> All records          | <input type="checkbox"/> Diagnostic imaging studies and reports |
| <input type="checkbox"/> Office visits        | <input type="checkbox"/> X-Ray films                            |
| <input type="checkbox"/> Immunization report  | <input type="checkbox"/> HIV or STD records                     |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Psychotherapy notes                    |
| <input type="checkbox"/> Procedure notes      | <input type="checkbox"/> Pathology reports                      |
| <input type="checkbox"/> Laboratory reports   | <input type="checkbox"/> Diagnostic test reports                |
| <input type="checkbox"/> Other _____          |   |

**Purpose for use or disclosure of health information:**

- The use or disclosure is at the request of the individual
- The use or disclosure is for a potential or pending legal proceeding
- Other (please describe): \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time; however, the revocation will not apply to information that has already been released in response to the authorization. To revoke this authorization, I must submit a written revocation to Emergency Responders Health Center. I understand that Emergency Responders Health Center will not base my treatment or payment upon whether I provide an authorization for the requested use or disclosure unless the provision of health care is solely for the purpose of creating health information for disclosure to a third-party (such as a fitness-for-work exam). I understand that information disclosed by Emergency Responders Health Center pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations. I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

(AUTHORITY OR RELATIONSHIP TO PATIENT)