Spokane Midwives

127 E Euclid Spokane WA 99207
Office: (509) 326-4366 Fax: (509) 328-9266

I hereby authorize the use or disclosure of health information as described below:

_____of_____,
Practitioner's name facility name

To release: Chart records for _____(do not include billing information or X-ray images).
Include all chart notes, laboratory results, medication list, and ultrasound reports.
Also to include (**initial** each of the following items for release):
_____HIV/AIDS/STD records
_____Mental health information
_____Genetic testing information
_____Drug/alcohol abuse/dependency diagnosis, treatment, or referral information
From the health records of:

Name: _____Other name: _____

Social Security number: _____Date of Birth ____/_____/_____
To be released to:
_____Spokane Midwives as listed above

_____Other_____

I understand I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, which by law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:_____ If I fail to specify an expiration date or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by confidentiality rules.

_____ _____
Signature of Patient/Guardian Date

*******CONFIDENTIALITY NOTICE*******
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This information may be disclosed to and used by the following individual or organization: Intercare Insurance Services, LLC; PO Box 52810; Bellevue, WA 98015 ; for the purpose of evaluation of a professional liability claim. **Rev 1/18, 10/18**