PUGET SOUND
SPINE & SPORTS MEDICINE

p: 206.776.2888
f: 206.776.2889
1700 Westlake Ave N, Suite 400
Seattle, WA 98109
www.soundspineandsport.com

Patient Authorization to Release and/or Disclose Protected Health Information

I. Patient Information

Full Name	
Former Name(s) *If applicable*	
Date of Birth	Phone Number
Address	

II. Purpose of Disclosure

◯ Provider ◯ Insurance Company ◯ Personal/Self
◯ Attorney ◯ Other (please specify):

III. Records to be RELEASED FROM:

◯ Puget Sound Spine and Sports Medicine
◉ Other: _____

IV. Records to be DISCLOSED TO:

Name Puget Sound Spine and Sports Medicine	Phone (206) 776-2888	Fax (206) 776-2889
Address 1700 Westlake Ave N Suite 400 Seattle, WA 98109		
Email info@pugetspine.com		

V. Records to be disclosed:

☐ **All Records** (includes all chart notes, imaging reports, outside reports/records, clinic summary)
from date: _____ **to date:** _____
Most recent 2 years will be provided if dates are not specified

☐ **Images** (specify specific study or all on file): _____

☐ **Other** (specify): _____

☐ **Verbal communication only** (no records will be sent unless indicated by additional selections)
Choose this option to permit conversations about your care with the person(s) specified above.

_____(initial) **I give special permission to release any information regarding:**
☐ Substance Abuse ☐ Psychiatric/Mental Health Information ☐ HIV information

This authorization is in effect until _____(date) or until revoked by you. If no date is selected, the authorization will expire after 1 year.

VI. **Preferred delivery method:** *Please note, imaging records must be picked up or mailed. All other records will be delivered by secure link sent via email unless otherwise specified*.

- ☐ **Secure link via email** (specify email address in Section IV)
- ☐ **Fax** (specify fax number in Section IV)
- ☐ **Mail** (specify address in Section IV)
- ☐ **Pick up in person** (please coordinate with our office)

By signing below, I acknowledge that I have read and agree to the terms in this document, Patient Authorization to Release and/or Disclose Protected Health Information.

I understand I may revoke this authorization at any time and may do so by submitting a request in writing to Puget Sound Spine and Sports Medicine at 1700 Westlake Ave N, Ste 400 Seattle, WA 98109.

I understand that, in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my protected health information.

I understand that I do not need to give any further permission for the information detailed in this document to be shared with the person(s) or organization(s) listed in this document.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

_____	_____	_____
Signature	Printed Name	Date