CLINIC 5Ĉ

Medical Records Release Form

Patient Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ Email: _____

Information to be released:

___ All Records
___ History and Physical
___ Lab Reports
___ Other _____
___ Records from date range _____
___ Recent EKG
___ Chart Notes

Reason for Request:

___ Preoperative Examination
___ Other: _____

The above information may be released TO:

Clinic 5c: Chesnut Institute of Cosmetic and Reconstructive Surgery
510 S. Cowley St. Spokane, WA 99202
Phone: 509-252-1299 Fax: 844-908-1414

Requesting medical records FROM:

_____
Name of Person or Entity to Release Information

_____
Street Address City, State, & Zip Code

_____
Phone #

_____
Fax #

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I do not have to sign this authorization in order to receive treatment from Clinic 5c/ CICRS. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Clinic 5C/ Chesnut Institute of Cosmetic and Reconstructive Surgery PLLC. By signing, I authorize the release of information specified above.

_____ _____
Patient (or guardian, if minor child) Signature Date

_____
Clinic 5C Staff Signature