

Spokane  
122 W. 7<sup>th</sup> #450  
Spokane, WA 99204  
509-838-2960  
800-ICA-7060  
509-459-0424 Fax

North Spokane  
9631 N. Nevada #302  
Spokane, WA 99218  
509-466-1563  
509-466-1607 Fax



**Inland Cardiology Associates, P.S.**  
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Coeur d'Alene  
980 Ironwood, #205  
Coeur d'Alene, ID 83814  
208-765-2610  
208-765-0635 Fax

Richland  
900 Stevens Dr, Ste 101  
Richland, WA 99352  
509-946-2699 - Office  
866-374-1959  
509-946-2688 - Medical Records  
509-946-2690 Fax

### AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This authorization is voluntary. I authorize the use or disclosure of the protected health information described below to be released from and sent to the following:

**\$22.00 clerical fee is required to process this request. Make check payable to Inland Cardiology Associates.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Daytime Phone (s) \_\_\_\_\_ SS# \_\_\_\_\_

**Information to be released from:**

| Name | Address | Phone #Fax # |
|------|---------|--------------|
|      |         |              |

**Information to be sent to:**

| Name | Address | Phone #Fax # |
|------|---------|--------------|
|      |         |              |

**Information to be Disclosed:**

Specific information checked below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> All chart notes  | <input type="checkbox"/> Nuclear Studies              | <input type="checkbox"/> Echocardiogram |
| <input type="checkbox"/> Vascular Studies | <input type="checkbox"/> Holter                       | <input type="checkbox"/> Lab            |
| <input type="checkbox"/> EKG              | <input type="checkbox"/> Other (please specify) _____ |   |

**Purpose for which disclosure is being made:**

- Legal       Insurance       Treatment       Medical Referral       Job       Personal  
 Other: \_\_\_\_\_

**Specific Authorization:**

I understand that my records may contain information regarding the testing, diagnosis and/or treatment of **HIV/AIDS, sexually transmitted diseases, drug and/or alcohol diagnosis/treatment, genetic testing, mental illness and/or psychiatric diagnosis/treatment.** I give my specific authorization for these records to be released.

**My Rights:**

I understand I have a right to request and receive a Notice of Privacy Practices. I may inspect and receive a copy of my medical records (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization. I may revoke this authorization in writing by presenting it to Inland Cardiology Associates Privacy Officer, but the revocation will not apply to information already used or disclosed. I understand that once the health information I have authorized to be disclosed reaches the above recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

**Expiration: I understand this authorization will expire 90 days from the date signed.**

SIGNATURE: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent, Guardian, or Authorized Representative: Please provide documents with authority to sign on behalf of Patient)