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Medical Records REQUEST/RELEASE

Patient Name:

Address:

City, State, Zip:

Telephone:

SSN:

Birthdate:

Consent for Release of Medical Information

I authorize: **Seattle Spine & Sports Medicine**

Provider's Name:

Richard Seroussi MD Virtaj Singh MD Benjamin Snyder MD Joseph Wilmhoff ARNP

To (Check one or both):

REQUEST my medical information FROM:

RELEASE my medical information TO:

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's Notice of Privacy Practice as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate treatment among health care providers who may be involved in my care.
- Obtain payment for my health care services from third-party payers and/or my legal representative (i.e. my attorney), as applicable.
- Conduct normal health care operations.

Patient Signature:

Date: