PALOUSE SURGEONS | LINEA COSMETIC SURGERY

2301 W. A St. Suite A :: Moscow, ID. 83843

RECORDS RELEASE &AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Full Legal Name of Patient (Please Print) :_____

Maiden Name/Alias/Preferred Name:_____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED IS:

- ☐ **ALL HEALTH CARE INFORMATION** in the medical record
- ☐ Health care information in the medical record related to the following treatment or condition: _____
- ☐ Health care information in the medical record for the date (s): _____
- ☐ Other (e.g. x-rays, bills), specify date (s): _____

This record is requested for the following reason:

- ☐ Continued Medical Care
- ☐ Legal Purposes
- ☐ Insurance Purposes
- ☐ Personal Interest
- ☐ Other (specify) _____

I request and authorize: To release my records to:

I request and authorize:	**To release my records to:**
Palouse Surgeons/Linea Cosmetic Surgery 2301 West A street, suite A Moscow, Idaho 83843 Phone: 208-882-1700 Fax: 208-882-1778	Stiller Aesthetics 805 West 5th Ave, suite 619 Spokane, Washington 99204

I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or bloodborne infectious disease, which are subject to federal and/or state restrictions on disclosure. If Palouse Surgeons, LLC is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

SIGNATURE: _____ **DATE:** _____
Patient, Parent, or Legally Authorized Individual

Relationship to the Patient: _____

Social Security Number: _____ Phone Number: _____