House of Healing

7 S Howard St, Suite 210
Spokane, WA 99201
P: 509-688-0147
F: 509-688-0148

Authorization to Release of Protected Health Care Information

Patient's Full Name:_____

Date of Birth:___/___/____ SS#:_____Phone #: (____)_____

I request and authorize_____to release health care information of the patient named above to:

House of Healing, PLLC
Dr. Pamil P Sidhu, MD
7 S Howard St, Suite 210
Spokane, WA, 99201

This request and authorization apply to:

☐ PROGRESS NOTES- Most recent one (1) year of relevant information.
☐ ALL LAB REPORTS.
☐ ALL IMAGING REPORTS.
☐ MEDICATION LIST.

Purpose for which the disclosure is being made: (Please select one)

☐ Specialty Care ☐ Personal Use ☐ Legal ☐ Transfer of Care ☐ Insurance

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and/or HIV status. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

Please initial: I DO_____DO NOT_____authorize this information to be released.

Limitations if any:_____

Authorization for the Use, Disclosure or Release of Protected Health Information
I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that House Of Healing PLLC will not deny treatment or payment based upon whether I sign this authorization. I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization
I understand that I am entitled to a copy of this authorization after I sign it.

Signature of patient:_____Date: _____