

**SOUND INPATIENT PHYSICIANS, INC.
AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS**

Patient Name: _____
DOB: _____ SSN: _____ Phone: _____
Address: _____

I hereby authorize Sound, and/or its affiliates, to:

- release copies of billing or medical records to the following persons or entities
 receive copies of billing or medical records from the following persons or entities

The following information shall be obtained and/or released pursuant to this Authorization:

Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm.

NOTICE TO PATIENT/PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or health care clearinghouse, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be obtained and/or disclosed for the following reason(s):

<input type="checkbox"/> Treatment/Continuity of Treatment	<input type="checkbox"/> Legal Reasons
<input type="checkbox"/> AT THE REQUEST OF THE INDIVIDUAL	<input type="checkbox"/> Assessment & Evaluation
<input type="checkbox"/> Marketing	<input type="checkbox"/> Other (specify):

Sound and/or its affiliate will / will not (cross out one) receive compensation, whether monetary or otherwise, as a result of the use or disclosure of this information for marketing purposes.

This authorization will expire: 90 days from the date of the signature below,
Or other: _____

This Authorization may be revoked by notifying Sound in writing addressed to:

**James Kodjababian, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422**

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Sound and/or its affiliates.

Patient Signature

Date

Personal Representative's Signature

Date

Personal Representative's Relationship/Authority

This Authorization is voluntary. A refusal to sign will **not** affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits.