SPERO CONSULTING PLLC

Authorization for Release / Receipt of Medical & Mental Health Records

Patients Full Legal Name	Date of Birth
Facility or Provider	Phone Number
Address / City	Fax Number

I hereby authorize: ❑ James Hughes, MD ❑ Christina Hughes, MD to: ❑ **RECEIVE** ❑ **RELEASE**

my health record which may include but is not limited to medical and psychiatric records, drug and alcohol treatment records, information regarding HIV / AIDS, diagnosis, progress notes, psychiatric evaluations, testing results, therapy notes, sexual assault / domestic violence notes, sexually transmitted disease information, medications lists and billing information to and/or from the facility/provider listed above. I understand that I have the right to revoke this consent at anytime, except to the extent that the person instructed to make the disclosure has already acted upon it. If not previously revoked, this consent will expire one year from the date of signature. I understand I have the right to refuse to sign this consent. Treatment will not be denied if consent is refused.

Type of information released/requested:

- ❑ Verbal Exchange
- ❑ Written Progress notes and Evaluations
- ❑ Lab/X-Ray reports (specify)_____
- ❑ Hospital Records (date)_____
- ❑ Other:_____

If requested, please fax or send records to:

Spero Consulting PLLC
110 James Street, Ste. 104
Edmonds, WA 98020
Phone: 425-412-8133
FAX: 425-412-8136

Signed: _____ _____
Patient Signature Date

❑ Consent revoked/refused on: _____ by _____