John A. Hatheway, MD

E-Mail: info@northwestpaincare.com

Web: www.northwestpaincare.com

421 W. Riverside Ave, Suite 900 • Spokane, WA 99201
Phone: 509-863-9789 Fax: 509-255-7793

November 1, 2024

Dear Patient,

To begin, I would like to thank you for the trust you have given me over the years as your physician. Your continued wellness and health are priorities for us.

After nearly 18 years serving the Spokane community, I am closing Northwest Pain Care permanently on December 20, 2024. I have not made this decision lightly. Our lease in the historic Paulsen building ends soon, and my wife, Kathy, and I have decided it is time to move closer to family on the west side of Washington. I am joining Virginia Mason Franciscan Health in the Puget Sound, where I will continue to practice interventional pain medicine.

It is important that you continue with appropriate medical care; therefore, you should establish contact with another pain management physician as soon as possible. My team and I will work with you toward that end. In the meantime, I remain available for your urgent pain care. Please rest assured that our office will remain available during the next 3 months to consult with your new provider to promote a smooth transition and continuity of care.

The enclosed HIPAA-compliant authorization form is necessary to release a copy of your medical records to you or your new physician. Please complete the form and return it as soon as possible. On receipt of this signed form, my office will forward a copy of your medical records to you or the physician you designate.

Please refer to the reverse side for helpful FAQs.

Sincerely yours,

John A Hatheway, MD

Enclosure: Authorization for Use or Disclosure of Health Information

NWPC Closure FAQ Sheet

How can I obtain my medical records?

*Submit a written request using the enclosed HIPAA form by January 3, 2025

*For assistance obtaining your records in person at our office, please call ahead. Our team can be reached by phone until January 31,2025. See contact info below.

*You may access your records through May of 2025 via the eClinical Works online portal as follows:

https://mycw193.ecwcloud.com/portal24605/jsp/100mp/login_otp.jsp

How do I settle my bill?

*Please call in your final payment to our office on or before December 19, 2024.

*Mailed payments can be received at our business address. See contact info below.

How can I reach NWPC after it has closed?

*After closure, you may consult our website, www.northwestpaincare.com for updated information. Phone access will be turned off after January 31, 2025.

Contact Information

Phone: **509-863-9789 (Through January 31, 2025)**

Fax: **509-255-7793 (Through May 31, 2025)**

Email: **info@northwestpaincare.com (Through the year of 2025)**

Mail **421 W. Riverside Ave, Suite 900**
Spokane, WA 99201 (Through February, 2025)

421 West Riverside Ave., Suite 900
Spokane, Washington, 99201
Phone: 509.863.9789
Fax: 509.255.7793

Authorization for Release of Information

I, ____ , hereby authorize **Northwest Pain Care, P.S.** to provide the
Patient Name

following records to ____
Name and Address of Receiving Individual/Facility

for the purpose of ___________________________ for the dates of service ___________________________ :

__ Pertinent Records

__ Lab Reports

__ Diagnostic Imaging

__ History & Physical

__ Office Visit Note

__ Discharge Summary

__ Operative Report

__ Injection Reports

__ Physical Therapy Notes

__ Other (specify) ___________________________

I understand that the information used or disclosed may be subject to re-disclosure by the recipient. This authorization is **valid for 90 days** unless revoked in writing. I understand that I have the right to revoke my authorization at any time, and that my revocation must be in writing to be valid, except as documented in the Washington State Health-care Information Act (Section 203) and unless the disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an emergency situation.

Signature ___________________________________ Date/Time ___________________________________

Print Patient Name ___________________________ Date of Birth ________________________________

Address and Phone Number

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