HEALTHCENTER NORTHWEST

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date: _____ Authorization #: _____

Patient Name: _____

Date of Birth: _____ SSN: _____

Information to be released from:

This information may be given to and used by the following individual or organization:

Information to be used for the purpose of:

☐ Requested by Patient ☐ Other_____ ☐ Comparison ☐ Permanent Transfer

I hereby request and authorize you to release information to:

Name: _____

Address _____

_____

Disclosure Method

☐ Pickup ☐ Mail

☐ Fax # _____

☐ Other _____

I authorize the use or disclosure of the above named individual's health information as described below.

Information to be released:

☐ All Records of Treatment from _____ to _____

☐ Entire (Complete Record)	☐ Medication Record	☐ Allergy List	☐ Mammogram- ☐ reports or ☐ films / CD
☐ History & Physical Report	☐ Physician's Orders	☐ Drug/ Alcohol Information	☐ Ultrasound- ☐ reports or ☐ films / CD
☐ Consultation Report	☐ Progress Notes	☐ Psychiatry Information	☐ Xray- ☐ reports or ☐ films / CD
☐ Operative Report	☐ Lab Results	☐ CT- ☐ reports or ☐ films / CD	☐ Other _____
☐ Immunization Record	☐ HIV Results	☐ MRI- ☐ reports or ☐ films / CD	

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand there will be a charge for copying records.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ .
  If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- I understand that I may revoke this authorization in writing at any time by contacting the Privacy Officer at (phone number) _____ .
- I understand that this revocation does not apply to information that has already been released to this authorization.
- Failure to sign this authorization
  - ☐ Will have no adverse impact on delivery of care or reimbursement of patient charges
  - ☐ Will have the following impact:_____

_____

_____

Signature of Patient or Legal Representative Date/Time

_____

If signed by Legal Representative, Relationship to Patient Signature of Witness Date/Time

For Office Use Only: Copied by:	☐ Check ID Type: _____ Date Copied:	Amount Received: _____:

- I revoke (cancel) this Authorization to Disclose health Information previously signed on _____ (date).

_____

Cancellation Signature Date/Time