



Northwest Surgical Specialists, P.C.

Release of Information: Phone (360) 449-1141, Fax 449-1146

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient date of birth: \_\_\_\_\_ Patient phone: (\_\_\_\_) \_\_\_\_\_

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

I, (print name) \_\_\_\_\_ hereby authorize the staff of Northwest Surgical Specialists, P.C. to release my health record information as specified below:

Purpose:  Continuation of care  Personal use  Insurance  Legal action  Other

MAIL  FAX TO:

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_\_

**I authorize the release of the following information:**

- Complete Medical Records
- X-Ray/MRI images
- Medical Records related to treatment of: \_\_\_\_\_

Medical Records for the date(s) \_\_\_\_\_

Other (specify): \_\_\_\_\_

**This authorization ends (check one):**

- on (date) \_\_\_\_\_
- 90 days from date signed

I understand that I may revoke this authorization by submitting a written request. The revocation would not affect any actions taken prior to notification of revocation, and I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand the information released may be subject to re-disclosure by the person or class of persons or facility receiving it, and that privacy laws may no longer protect it.

I further authorize the release of health care information regarding testing, diagnosis and/or treatment for:

- HIV(Aids Virus)  Psychiatric disorders / mental health
- Sexually transmitted diseases  Drug and/or alcohol use

Signed: \_\_\_\_\_  
Patient or legally authorized individual

Date: \_\_\_\_\_

**If signed on behalf of the patient:**

Print your name: \_\_\_\_\_

Describe your authority to act on behalf of the patient:

- Parent or legal guardian (if patient is a minor)  Durable power of attorney for healthcare
- Court-appointed personal representative  Other: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_