MRN:______________

ALL HIGHLIGHTED AREAS MUST BE COMPLETED IN ORDER TO RELEASE RECORDS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ______________________________ Patient Date of Birth: ____________ Date: ____________

Patient Phone: ____________________________ Patient Email Address: ______________________________

(If Enrolled in Patient Portal)

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 ❒ Other: ______________________________

Method: ❒ Mail ❒ Fax ❒ Patient Portal (not for Images) ❒ Electronically to: ______________________________

Release My Health Record Information to:

Name: ______________________________ Address: ______________________________

______________________________ ______________________________

Relationship to Patient: ____________________ City: ______________________________

Fax #: ______________ Email: ______________ State: ____________ ZIP: ______________

I Authorize the Release of the Following Information: (Check Boxes That Apply)

❒ Notes Relating to a Specific Body Part or Date Range Only: ______________________________

❒ Chart Notes and Reports Only

To request your complete medical record, please use our Comprehensive Medical Records Release Form. (Fees may apply.)

❒ Diagnostic Image CD (X-Ray/MRI/CT) **: Not Currently Available Via Patient Portal**

This authorization ends on (date) ____________________ (**if not specified, expires 90 days from date signed**).

I understand I do not have to sign this authorization in order to receive healthcare or benefits, except to participate in a research study or create healthcare information for a third party. 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 healthcare information regarding testing, diagnosis, and/or treatment for:

❒ HIV (AIDS Virus) ❒ Psychiatric Disorders/Mental Health ❒ Sexually Transmitted Diseases ❒ Drug and/or Alcohol Use

Signed: ______________________________ Date: ______________

Patient or Legally Authorized Individual

Medical Records

X-Ray

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: ______________________

----------FOR OFFICE USE ONLY----------

Verified Photo ID: ____________ ❒ Diagnostic Image CD Released at Reception or in Clinic ❒ Chart Notes Released at Reception or in Clinic

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