ALL HIGHLIGHTED AREAS MUST BE COMPLETED IN ORDER TO RELEASE RECORDS

AUTHORIZATION TO RELEASE COMPREHENSIVE MEDICAL RECORDS

Patient Name: _____ Patient Date of Birth: _____ Date: _____

Patient Phone: _____ MR #: _____
(Only Needed When Patient Is Enrolled in 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 : _____

Mail My Complete Medical Record to:

Name: _____ Address: _____

_____ _____

Relationship to Patient: _____ City: _____

_____ State: _____ ZIP: _____

I authorize the release of my complete medical record (each and every document, including diagnostic images on a CD). Fees may apply.

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 health care 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

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: _____

Verified Photo ID: _____

Medical Records

X-Ray

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