

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/ RI/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**

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: _____

X-Ray

-----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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