rebound ORTHOPEDICS & NEUROSURGERY
The Region's Most Preferred.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Note: To avoid delays, print clearly and sign. Please complete all requested fields (*)

Information about the patient whose records are being requested:

***Name:** _____ ***Date of Birth:** _____

***Address:** _____ ***State:** _____ ***Zip Code:** _____

***Phone:** _____ **Email:** _____
(If Enrolled in Patient Portal)

I hereby authorize Northwest Surgical Specialists, P.C., (dba Rebound Orthopedics and Neurosurgery) to release my health record information as specified below:

***Visit Date Range:** From: _____ To: _____ Other: _____

***Information Needed:** (Rebound will provide images link for images request. Please contact us if CD is the only option and a $6.50 fee may apply.)

☐ Records relating to (body parts): _____ ☐ Billing ☐ Labs

☐ Diagnostic Image Link (Please provide email address) ☐ Other: _____

☐ Complete medical records (this would include all records, including billing record, lab, and images for dates identified above)

***Purpose of Disclosure:** ☐ Continuity of Care ☐ Personal Use ☐ Other: _____

***Send my records to (Recipient):** ☐ Send to patient address above **OR** ☐ Send to the below recipient

Facility Name: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

***How to send Records:** ☐ Mail to patient address ☐ Email to: _____

☐ Fax to: _____ ☐ Mail to the Facility's Address listed above

☐ Other: _____

I understand that I may be charged a reasonable, cost-based fee that covers the cost of copying, including supplies, labor, and postage. 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. I understand the information released may be subject to re-disclosure by the person or facility receiving it and that privacy laws may no longer protect it. I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this form. I understand that I must provide legal documentation if I am a legal guardian or Medical Power of Attorney.

I further authorize the release of healthcare information regarding testing, diagnosis, and/or treatment for:
❒ HIV (AIDS Virus) ❒ Psychiatric Disorders/Mental Health ❒ Sexually Transmitted Disease ❒ Drug and/or Alcohol Use

This authorization ends on (date): _____ (if not specified, expires 90 days from date signed)

***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:
❒ Parents or Legal Guardian ❒ Durable Power of Attorney for Healthcare ❒ Court-Appointed Personal Representative
❒ Other: _____

Options for returning this completed form to us: **Fax:** 360-803-0847 **Email:** Medicalrecords@reboundmd.com

Mail to: Rebound Medical Records Department at 200 NE Mother Joseph Place, Suite 210, Vancouver, WA 98664

Questions? Call 360-449-1141

Revised 09/2026