

**Outgoing Medical Records Request Form
Authorization for Northwest Physiatry Associates to Use or Disclose My Health Care Information**

Patient name: _____ Date of birth: _____

Previous name(s): _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
☐ Health care information in my medical record relating to the following treatment or condition:

- ☐ Health care information in my record for the date(s): _____
☐ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus) ☐ Psychiatric disorders / mental health
☐ Sexually transmitted diseases ☐ Drug and/or alcohol use

Please disclose this health care information to:

Name (or title) and organization: _____

☐ By fax to the following fax number: _____

☐ By U.S. mail to the following address:

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

Reason(s) for this authorization (check all that apply):

- ☐ At my request
☐ Other (specify): _____

This authorization ends:

- ☐ In 90 days from the date signed (maximum duration permissible).
☐ On (date): _____
☐ When the following event occurs (not extending beyond 90 days from today): _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Northwest Physiatry Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Northwest Physiatry Associates, or
- Write a letter to Northwest Physiatry Associates.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature Date Time

Printed name Relationship (parent, legal guardian, personal representative)
0707 2008 0910