NW Physiatry Associates

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Specialists in electrodiagnosis and rehabilitation medicine

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:
_____
☐ Office visit notes in my medical 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)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ 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 the Northwest Physiatry Associates. Or
- Write a letter to the 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)

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