Northwest Medical Associates, P.S.
Authorization for Release of Information

Patient Name _____ **Date of Birth** _____ **SS#** _____

Information to be released from: _____
Name of designated Facility or Provider

_____
Address

_____
City, State, Zip Code Phone

Information to be sent to:
Northwest Medical Associates, P.S.
222 NE Park Plaza Dr, Suite 100
Vancouver, WA 98684-5899
(360)-254-8025

Information to be released:

☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)

☐ All Medical records

☐ Specific Information (please specify): _____

_____

Purpose for which disclosure is being made: (please check one of the following)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

____ Drug/Alcohol abuse/treatment & diagnosis ____ Sexually Transmitted Disease

____ HIV/AIDS diagnosis/treatment/testing ____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____
Signature of Patient/Personal Representative Date

This authorization will expire 90 days from the date signed.
Possible copying fee required

Revised 4/2013