AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

NORTHWEST NEUROSPECIALISTS PLLC
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PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	State	Zip Code
Phone Number (if we have any questions)	Fax Number (if applicable)	MRN	

RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record from:

Physician/Facility			
Address	City	State	Zip Code
Phone Number	Fax Number		

RELEASE TO: [Name of physician or facility receiving information]

Please send my medical record to:

Physician/Facility			
Address	City	State	Zip Code
Phone Number	Fax Number		

RELEASE INFORMATION

Reason: [ ] Change of insurance [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply):

☐ MEDICAL RECORDS/Excluding Protected Records (limited to 1 year of information unless otherwise stated)

☐ Other Records(specify)_____ Dates of Treatment From_____ To_____

	DATES		DATES
☐ LAST THREE OFFICE VISITS		☐ Include Outside Records from other physicians/facilities	
☐ LAB REPORTS		☐ BILLING RECORDS	
☐ RADIOLOGY REPORTS		☐ OTHER-PLEASE SPECIFY	
☐ SURGICAL REPORTS			

• Please allow 14 days for processing. • Incomplete information will delay processing.

CONSENT

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipients and not longer be protected by the Health Insurance Portability & Accountability Act of 1996 and subsequent amendments.

I authorize the release of the information indicated, and I am aware that the records released may contain references relating to psychiatric or psychological testing, physical abuse, drug and alcohol abuse or genetic testing.

	YES	NO	Initials
I authorize the release of information relating to HIV/AIDS testing and/or treatment			
I authorize the release of information relating to psychiatric or psychological testing/treatment			
I authorize the release of information relating to substance abuse diagnosis and/or treatment			
I authorize the release of information relating to genetic testing to include diagnosis/treatment			
I understand that I may be charged for copies provided. If a charge applies, I will be notified of the amount before the records are processed.			

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for 2 years. It may be revoked by the signer at any time. NNS082011