Northwest Family Medicine

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

PATIENT NAME:

Name_____ Previous Name_____ Date of Birth_____

I, THE PATIENT/GUARDIAN, AUTHORIZE

Name of Provider_____ Ph_____ Fax_____

Address_____ City/State/ZIP_____

TO DISCLOSE MY MEDICAL RECORDS TO:

Name_____ Ph_____ Fax_____

Address_____ City/State/ZIP_____

INFORMATION TO BE DISCLOSED:
☐Chart note(s)
☐Laboratory Report(s)
☐Diagnostic Imaging Report(s)
☐Everything (chart notes, labs, imaging, specialized testing, vaccine record, growth charts)
☐What time period do you want disclosed?_____
☐Other_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____**Alcohol/Drug Abuse**
_____**HIV/Aids Test Results**
_____**Mental Health/Developmental Disabilities**
_____**Genetic Testing**

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/ alcohol diagnosis, treatment or referral information.

PURPOSE for release of records _____

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have read this information and understand it. (Please print, sign name and date below)

Please print your name if you are signing but are not the patient._____

Signature_____ Date_____