



Northwest Health Services, Inc.

AUTHORIZATION FOR USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION

I hereby authorize _____
 (Name and address of organization who has the requested records)

 (complete name and address required)

_____ use the following protected health information, and/or

_____ release the following protected health information to

PHI released to: _____
 (Name of organization you want your records sent to)

 (complete name and address required)

This protected health information is being used or disclosed in the following manner (list specific purpose here):

- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Northwest Health Services

 (Address of clinic that has your records)

****I authorize the release of the following components of my Private Health Information:**

Medical record
 Date(s) authorized to be released _____ to _____
 X-rays only _____
 Laboratory reports only _____

I understand that the release of my complete record may include the following: HIV testing and results, mental health and/or substance abuse records. _____ (Patient's initials)

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. Requests for access will be granted within 30 days of receipt unless patient is notified otherwise. Applicable fees will be applied
- Refuse to sign this authorization.

I understand this consent and authorization may be revoked at any time except to the extent already acted upon. This consent and authorization expires on _____ or within one (1) year of the date signed if I have not provided an expiration date.

 Signature of Patient or Personal Representative

 Date of Birth

 Date

 Social Security Number

 Printed Name of Patient or Personal Representative
 2005

 Description of personal representative