NORTHWEST HEALTH SERVICES

AUTHORIZATION TO USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____
(Full Name) (Date of Birth) (Social Security Number)

Hereby grant: *Name and address of doctor/organization that has my records*:
(Complete name and address is required)

_____

_____

To release my information to: *Name and address of doctor/organization you want your records sent to:*
(Complete name and address is required)

_____

_____

I authorize the release of all *OR* the following parts of my Private Health Information: (Please Initial)

Medical Record_____ Between the dates of _____to_____

X-rays only_____ Laboratory reports only_____

Other (Please Specify) _____

I understand the release of my complete medical record may include information such as:

HIV testing and results; mental health and/or substance abuse records._____ **(Please Initial)**

I understand the information used or shared by this authorization may be re-disclosed by the doctor or organization that received it and may no longer be protected by federal or state law.

I understand:

- **I have the right to** inspect or copy the information to be used or shared as allowed under federal or state law.
- **I have the right to** ask for access to my medical information, and such request will be granted within 30 days unless I am notified otherwise.
- **I have the right to** refuse to sign this authorization and still receive treatment.
- There may be a fee for copying of my records.

I understand this consent and authorization may be cancelled at any time, except to the extent it has already been acted upon and information released as requested. This consent and authorization expires on_____, or 1 year from the date I signed the authorization if I have not provided an expiration date.

_____ _____
Signature of Patient/Legal Guardian or Representative Today's Date

_____ _____Printed Name of
Patient/Legal Guardian or Representative Relationship to Patient

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