Orthopedics Northwest, PLLC

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Phone: (509) 454-8888 - Fax: (509-453-0061

Patient Information:

RECORDS FROM OTHER CLINICS IN OUR POSSESSION NOT ORDERED BY OUR DOCTORS WILL NORMALLY **NOT** BE RELEASED

_____ **DOB:**_____
(Print name of Patient)

To be released from:

_____
_____
_____
_____

To be released to: (Name, Address, Phone, Fax)

_____
_____
_____
_____

Information to be released:

I hereby authorize and request the above-mentioned physician, hospital or association to disclose to facility or individual indicated the following information:

_____**CD of Xrays/MRI only (fee if for yourself)**

_____**Paper Records only (List body part/s)** _____

Purpose for which disclosure is being made: **At the request of the individual/patient.**

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, 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**
_____**HIV/AIDS diagnosis/treatment/testing**
_____**Sexually Transmitted Disease**
_____**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. This authorization will expire 1 year from the date signed.

_____ _____ _____
Date Signed **Signature of Patient, Guardian, or Personal Representative** **Phone**

KEEP A COPY FOR YOUR FILES. IF YOU REQUEST A 2ND SET FOR YOURSELF, THERE IS A FEE.

Records / X-rays to be: _____ **Picked up** _____ **Mailed** _____ **Faxed** _____ **Portal**

Office Use Only

	Date	Init		Date	Init
X-rays pulled	_____	_____	Records / X-rays given to_____	_____	_____
Records copied	_____	_____	Records / X-rays mailed to_____	_____	_____
			Records faxed to _____	_____	_____
			Called / Left Msg to P/U _____	_____	_____

Comments:_____

_____

_____