PT NORTHWEST

Authorization to Disclose Medical Records

I authorize _____

to release a copy of the medical information for:_____(Name of patient) DOB: _____

to: (Name & address of recipient): _____

_____

The information will be used on my behalf for the following purpose(s): _____

_____

_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ All hospital records (including nursing records and progress notes)

_____ Transcribed hospital reports

_____ Medical records needed for continuity of care

_____ Most recent five year history

_____ Laboratory reports

_____ Pathology reports

_____ Diagnostic imaging report

_____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

_____ *HIV/AIDS-related records

_____ *Genetic testing information

***Must be initialed to be included in other documents.**

_____ **Drug/alcohol diagnosis, treatment or referral information:

_____

_____ **Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

_____

_____ Clinical office chart notes

_____ Dental records

_____ Physical therapy records

_____ Emergency & urgency care records

_____ Billing statements

_____ Other: _____

_____

_____ This authorization is limited to the following treatment:

_____

_____ This authorization is limited to the following time period:

_____

_____ This authorization is limited to a workers' compensation claim for injuries of:

_____(date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. 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.

Signature of patient _____ Date _____

Signature of person authorized by law _____ Date _____