NORTHWEST GYNECOLOGY ASSOCIATES, LLC
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AUTHORIZATION TO OBTAIN & DISCLOSE MEDICAL INFORMATION

Please obtain medical records and information pertaining to medical history, mental or physical condition, service rendered, or treatment of:

Patient Name:_____ **Date of Birth:**_____

Address:_____ **SS#:**_____ **Phone:** _____

_____

Please **OBTAIN** information **FROM** the following:

_____
Name & Title of Provider / Organization

_____
Street Address

_____
City / State / Zip

Please **SEND** my medical information **TO:**

_____
Name & Title of Provider / Organization

_____
Street Address (or specified fax number)

_____
City / State / Zip

For the purpose of: ❑ Patient Care ❑ Insurance Claim ❑ Self ❑ Other_____

List specific dates of records to be released: _____

Duration: This authorization shall begin immediately and remain in effect until (date): or not more than 180 days from this date

Description or nature of information to be used and / or disclosed:

❑ Discharge summaries ❑ Operative reports ❑ All hospital records
❑ History & Physical Exams ❑ Radiology & Imaging reports ❑ Clinician office notes
❑ Consultations ❑ Laboratory report ❑ Billing statements
❑ Pathology reports ❑ Most recent 2 years ❑ Geripsych Screening
❑ Records for the following dates or treatment: _____
❑ Other (specify): _____

The following (*) must be initialed by the patient to be included in the use and / or disclosure of other health information:

_____ * HIV / AIDS related information and / or records _____ * Mental Health Information

_____ * Genetic Testing information _____ ** Drug / Alcohol referral information

** Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and / or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature: _____
(Patient / legal representative) Date Time

If signed by other than patient, indicate relationship: _____

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For Northwest Gynecology Associates Use Only:

Date Received:_____ ❑ Verification of Identity and Authority ❑ Fees explained if needed

❑ Records have been sent by: _____ Date:_____