

**Outgoing Medical Records Request Form**  
**Authorization for Northwest Physiatry Associates to Use or Disclose My Health Care Information**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name(s): \_\_\_\_\_

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record  
 Health care information in my medical record relating to the following treatment or condition:

- Health care information in my record for the date(s): \_\_\_\_\_  
 Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)  Psychiatric disorders / mental health  
 Sexually transmitted diseases  Drug and/or alcohol use

**Please disclose this health care information to:**

Name (or title) and organization: \_\_\_\_\_

By fax to the following fax number: \_\_\_\_\_

By U.S. mail to the following address:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

- At my request  
 Other (specify): \_\_\_\_\_

**This authorization ends:**

- In 90 days from the date signed (maximum duration permissible).  
 On (date): \_\_\_\_\_  
 When the following event occurs (not extending beyond 90 days from today): \_\_\_\_\_

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Northwest Physiatry Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Northwest Physiatry Associates, or
- Write a letter to Northwest Physiatry Associates.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative)