

**Incoming Medical Records Request Form**  
**Authorization to Disclose Protected Health Care Information to Northwest Physiatry Associates**

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

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

**I. My Authorization**

I authorize \_\_\_\_\_ to use and disclose to:

NAME OF DISCLOSING ENTITY - TO BE FILLED IN BY PATIENT

**Northwest Physiatry Associates, 1530 N. 115th St., Suite 305, Seattle, WA 98133, Phone 206.362.2464, Fax 206.362.2141, the following protected health 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 medical 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)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

**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 the Northwest Physiatry Associates. Or
- Write a letter to the 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)

0707 2008