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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
(FROM ANOTHER PARTY TO BE SENT TO NWOA)

1. Patient Name: _____ DOB: _____ Phone # _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____

2. From- I authorize (provider's name) _____, (address) _____,
(city) _____, (state) _____, (zip) _____, (phone)(_____) _____ - _____

to disclose the following information from the health records of the above patient: (X check all that apply)

- Limited to treatment dates for condition(s)/body part(s) as described: _____
Clinical office notes
Consultation reports
Surgical notes, reports, history & physical
Laboratory tests results
Hospital discharge summary
Payment records
X-ray reports(written)
X-ray Films(possible copy fee)
MRI Scan reports(written)
MRI Films(possible copy fee)
CT reports(written)
CT Films(possible copy fee)
Dexa Scan Reports(written)
Dexa Color Printout(possible copy fee)
Other: _____

3. I understand that according to the Privacy Laws I need to specifically authorize the following protected health information: (X check all that apply)

- Victim of a Crime or of Abuse, Neglect, or Domestic Violence. Some or all of the above information or injury being released may contain or be related to the above named patient being a victim of a crime or of abuse, neglect, or domestic violence.
Drug Abuse. Some or all of the above information or injury being released may contain or be related to Drug abuse. The above named patient understands that when he/she reaches their 13th birthday, they must sign for the release of records regarding Drug abuse information.
Alcohol Abuse. Some or all of the above information or injury being released may contain or be related to Alcohol abuse. The above named patient understands that when he/she reaches their 13th birthday, they must sign for the release of records regarding Alcohol abuse information.
Mental Illness or Psychiatric Treatment. Some or all of the above information or injury being released may contain or be related to Mental Illness or Psychiatric Treatment. The above named patient understands that when he/she reaches their 13th birthday, they must sign for the release of records regarding Mental Illness or Psychiatric Treatment information.
HIV+ / Aids Virus or other Sexually Transmitted Diseases. Some or all of the above information or injury being released may contain or be related to HIV+ / Aids Virus or other Sexually Transmitted Diseases. The above named patient understands that when he/she reaches their 14th birthday, they must sign for the release of records regarding HIV+ / Aids Virus or other Sexually Transmitted Diseases.
Sexuality & Reproduction. Some or all of the above information or injury being released may contain or be related to Sexuality & Reproduction information. The above named patient understands that when he/she reaches their 14th birthday, they must sign for the release of records regarding Sexuality & Reproduction information.

4. Sent to-Disclose this information to:

Northwest Orthopaedic Associates: 875 Swift Blvd., Richland, WA 99352

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5. Purpose of disclosure: _____

_____ Date _____ Date _____

6. Patient's Signature or Legal Rep. Signature _____ Person Requesting Information (please print) _____

I understand that this release will be for a maximum of 1 year, unless I specify other dates below. I have the right to cancel this request with a written notification, but it will not effect any information released prior to receipt of cancellation. I understand that the information requested may be reviewed by the provider before being released. I understand that the information use or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to who this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization. Release Dates- Start: _____ End: _____

Sent by: _____ Date Sent: _____