AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NORTHWEST
MEDICAL GROUP

Patient Information:

Patient Name: _____ Date of Birth:_____ / ____ / _____
Last *First* *M.I*

Address: _____ Phone Number: _____
Street *City* *State* *Zip Code*

Records to be released from:

Northwest Medical Group PLLC *Phone: 509-350-4785*
821 E Broadway Ave Suite 1, Moses Lake, WA 98837 *Fax: 509-380-9591*

Records to be released to:

Name or Person/Entity: Phone _____

_____ Fax: _____

Address of Person/Entity: Email: _____

_____
Street *City* *State* *Zip Code*

Purpose of Release:

- ☐ Continuing/Traferring Care
- ☐ Attorney/Legal
- ☐ Insurance Company
- ☐ Other
- ☐ Personal Use
- ☐ Billing/Claims
- ☐ School/Employment

Information to be Disclosed:

- ☐ Office Visit
- ☐ Immunizations
- ☐ Discharge Summary
- ☐ X-Ray Imaging
- ☐ Labs
- ☐ Procedure Report
- ☐ History & Physical Report
- ☐ Imaging Report
- ☐ Medications
- ☐ Emergency Report
- ☐ Billing Records
- ☐ Other: _____ Specific Dates/Years: _____

Authorization:

I understand that: Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations. I have the right to revoke this authorization at any time. Revocation must be made in writing and send to the Health Information Management Department at the following address: Northwest Medical Group, 821 E Broadway Ave Ste 1, Moses Lake, WA 98837 or by email at occmed@nwmedicalgroupwa.com. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date signed. Treatment, payment or eligibility for benefits may not be conditioned on whether I sign this authorization. Any diclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal confidentiality rules.

_____ Date: _____
Printed Name of Patient/Legal Representative

_____ Relationship to Patient:_____
Signature of Patient/Legal Representative