AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
NORTHWEST OB-GYN, P.S.

Patient's name:_____ Date of birth:_____

SSN: _____ Previous name: _____

Daytime phone: _____ Date records needed by: _____

I request and authorize:	**to release health care information as indicated below to**:
Name: _____ Address: _____ _____ Phone: __(_____)_____ Fax: __(_____)_____	**NORTHWEST OB-GYN, P.S.** **105 WEST 8TH AVE., STE. 6020** **SPOKANE, WA 99204** **(509) 455-5050** **FAX (509) 624-5034 or (509) 747-5391**

Please check which request applies:

One (1) year of complete OB/GYN medical records ☐ ***including*** ☐ ***excluding*** any sensitive information regarding sexually transmitted disease, reproductive health, drug and alcohol history, mental health/physical abuse and HIV/AIDS information.

…Or

Specific information as follows ☐ ***including*** ☐ ***excluding*** any sensitive information regarding sexually transmitted disease, reproductive health, drug and alcohol history, mental health/physical abuse and HIV/AIDS information:

_____

PURPOSE OF DISCLOSURE: ☐Changing physicians ☐Consultation/second opinion ☐Continuing care
☐Legal ☐School ☐Insurance ☐Workers Compensation
☐Other (please specify):_____

Consent of a Minor: A minor patient's signature alone is required in order to release information concerning care for: (1) conditions relating to the minor's sexuality including, but not limited to reproductive health, sexually transmitted diseases (age 14 and above), (2) alcoholism and/or drug abuse (age 13 and above), (3) mental health conditions (age 13 and above).

_____ _____
Signature of Minor Patient Date signed

_____
Signature of Patient or Patient's Authorized Representative **Date signed**

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

This authorization expires **90 days** after the date it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.