NORTHWEST NEUROSPECIALISTS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Print

Patient's Full Name:____

Date of Birth: _______________ Social Security Number:_______________________

Patient's Address:____
Street City State Zip Code

THIS AUTHORIZES:____
Physician Name

____
Address City State Zip Code

TO RELEASE INFORMATION SPECIFIED TO:_______________________________
(Name of receiving party)

____
Address City State Zip Code

PHOTOCOPIES OF INFORMATION TO BE RELEASED:

______ Medical Records of the past two (2) years of treatment
Initials

______ Other Medical Information (please specify)_________________________
Initials

I also authorize release of records pertaining to:

______ All HIV-Related information and Communicable Disease-Related Information
Initials

______ Conditions related to psychiatric/psychological treatment
Initials

In accordance with Federal Regulations 42 CFR Part 2, I hereby consent to the release of records pertaining to the treatment/diagnosis of the following:

______ Conditions relating to substance and/or alcohol/drug abuse
Initials

I consent to the release of the specified information or medical records about my condition and the treatment and services I received to those persons or agencies listed. I further release Northwest NeuroSpecialists and any of its staff, employees and agents from any liability arising from the release of this information or records to such designated persons or agencies. I understand that I may revoke this consent at any time and upon fulfillment of the above stated purpose(s), this consent will automatically expire one (1) year following date of signature.

____ ____________________
Signature of patient/parent/guardian*/authorized representative* Date

*Copies of legal documents supporting legal representation of the patient MUST accompany this release form.
01/03