Northwest Psychiatry
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Information

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	

I request and authorize **Northwest Psychiatry** To ☐ **Provide** ☐ **Receive**
My Medical and Mental Health records ☐ **To** ☐ **From**

Healthcare Provider / Entity Information

Name:				Specialty:	
Street:					
City:		State:	Zip Code:	Tel:	Fax:

The Purpose Of Release:

This request and authorization applies to:

☐ **Continuation of Care**	☐ **Transfer of Care**	☐ **Coordination of Care**
☐ **Legal**	☐ **Other: (Please Specify)**	

Information To Be Released:

This request and authorization applies to:

☐ **Entire Record**	☐ **Visit Notes**	☐ **Labs /MRI /X-Ray**
☐ **Dates _____to_____**		

This Consent is subject to revocation at any time, except to the extent that action has been taken in reliance on the patient's consent.

Patient Signature:		Date Signed:	

NOTE TO RECEIVER (Notice Prohibiting Redisclosure): This information has been disclosed to you from records protected by federal confidentiality rules(42 CFR Part2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of rht person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.