

Pacific Northwest Audiology

Requests for Release of Medical Records

Patient Name _____ Date of Birth _____ Male/Female

Address _____ Phone _____

1. I hereby authorize **Pacific Northwest Audiology** to release information from my medical record to

2. Name _____

Address _____

For the purpose of (please check one)

Continued treatment - Legal review - Insurance purpose - Personal review of information - Other
(please specify) _____

3. I limit the information to be released to the following items: (Please check specific items)

Diagnostic tests and results – Consultation - Treatment plan - Other (please specify) _____

Covering records from on or about (Date) _____ to (Date) _____

4. **This authorization will automatically expire within six months from the date of signature.** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Pacific Northwest Audiology. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

6. I also understand that in an effort to prevent unauthorized re-disclosure Pacific Northwest Audiology attaches a notice when sending out records that states, “**re-disclosure is prohibited**”. However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

7. I also understand that in order to process this request to reproduce medical record information on a timely basis, Pacific Northwest Audiology, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

Print of Your Name (or Responsible Party*) _____

Signature _____ **Date** _____

(*Patient / Representative / Legal Guardian)