AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

( ) I authorize NORTHWEST MEDICAL GROUP to use and disclose medical information regarding my medical care.

Name of Patient: _____ DOB: _____

Consisting of **ANY AND ALL MEDICAL INFORMATION** _____

Name of Recipient(s): _____ Password_____

Phone #: _____

Name of Recipient(s): _____ Password_____

Phone # _____

Name of Recipient(s): _____ Password_____

Phone # _____

Name of Recipient(s): _____ Password_____

Phone # _____

If we are requesting this Authorization from you for our own use and disclosure, or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____
(Patient)

Or By: _____ Date: _____
(Patient's Legal Representative)

Description of Representative's Authority: _____