REQUEST TO COPY OR INSPECT PROTECTED HEALTH INFORMATION

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

HOSPITAL

PATIENT NAME/PREVIOUS NAME(S) _____ DATE OF BIRTH _____

STREET ADDRESS, CITY, STATE, ZIP CODE _____ PHONE NUMBER _____

RELEASE MY PROTECTED HEALTH INFORMATION TO: Myself ☐ Individual Noted Below ☐

INDIVIDUAL NAME _____

BUSINESS OFFICE (IF APPLICABLE) _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE # FAX#

INFORMATION TO BE DISCLOSED

Date(s) of Service: _____

___ Entire Medical Record

____ History and Physical ____ Operative reports ___Radiology Reports

____ Progress Notes ____ EKG Reports ___ Discharge Summary

____ Laboratory Reports ____ Consultations ___ Pathology Reports

Other: _____

EXCLUDE the following information from the records released: (please initial)

____ Drug/Alcohol abuse/treatment and diagnosis ____ Sexually transmitted disease

____ Mental Illness or psychiatric diagnosis and treatment ____ HIV/AIDS

This information is to be: ☐Mailed ☐Pickup ☐ Fax ☐ Inspect ☐ Email:_____

Please choose format: ☐ Paper Copy ☐ Electronic Media

This protected health information will be used by the Facility listed above for the purpose of treatment.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the provider(s) listed above.
I understand that a revocation is not effective to the extent that the provider(s) listed above have relied on this form to use or disclose protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy requirements law. However, the Facility is covered by federal privacy requirements and will follow them.
I understand that the provider(s) listed above will not condition treatment, payment, enrollment in a health plan or program, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to refuse to sign this authorization.

This authorization shall be in force and effect until _____ (date).

PRINTED NAME OF PATIENT/REPRESENTATIVE _____ SIGNATURE OF PATIENT/REPRESENTATIVE _____ DATE _____

Mailing Address: 1593 E Polston Ave, Post Falls, ID 83854 or Fax: 208-262-2382