REQUEST TO COPY OR INSPECT PROTECTED HEALTH INFORMATION

NORTHWEST SPECIALTY 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	_____ Radiology Images
_____ Laboratory/Pathology Reports	_____ Consultations	_____ Discharge Summary
_____ Anesthesia Records	_____ Implant Log	_____ Nursing Notes

_____ Other:_____

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

_____ Drug/Alcohol abuse/treatment and diagnosis
_____ Mental Illness or psychiatric diagnosis and treatment
_____ Sexually transmitted disease
_____ HIV/AIDS

We may be prohibited from making certain information available to you or to your representative, including:

-Psychotherapy notes
-Information related to medical research in which you have agreed to participate
-Information related to legal proceedings
-Information obtained under a promise of confidentiality
-Information that federal or state laws prevent us from disclosing
-Information for which the disclosure may result in harm or injury to your or to another person

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

Please choose format: ☐ Paper Copy ☐ Electronic Media: ☐ Disc ☐ USB ☐ Email

This authorization shall be in force and effect for 1 year from date of signature or until _____(date).

YOUR RIGHTS WITH RESPECT TO THIS REQUEST: Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request or provide you with a written explanation of any restriction on the information that we can provide you.

PRINTED NAME OF PATIENT/LEGAL REPRESENTATIVE _____ RELATIONSHIP TO PATIENT _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE _____ DATE _____

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

INTERNAL USE:

(HOW INFORMATION WAS PROVIDED) _____ (DATE) _____ (STAFF INITIALS) _____