

Medical Records Request

PATIENT INFORMATION		
LAST NAME	FIRST NAME	
EMAIL	PHONE	DATE OF BIRTH
ADDRESS		

Information to be Released:

- | | |
|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Records from Date Range: _____ |
| <input type="checkbox"/> History & Physical (Most Recent) | <input type="checkbox"/> Recent Imaging |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Chart Notes |
| <input type="checkbox"/> Other: _____ | |

Reason for Request:

- Ongoing/Continuation of Care Other: _____

The above may be released to:

Name of Person or Entity to Release Information

Street Address City, State & Zip Code

Phone # Fax #

Requesting medical records **from:** NW Wound Specialists
Phone & Fax: (509) 381-3540
Email: woundcare@upwellventures.com

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I do not have to sign this authorization in order to receive treatment from NW Wound Specialists. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to NW Wound Specialists. By signing, I authorize the release of information specified above.

Patient / Agent / Guardian Signature

Date

Relationship of Signer (If Other than Patient)