Northwest Oncology & Hematology, S.C.

Consent To Release Medical Records

This consent is valid for twelve (12) months after the date of patient's/representative's signature

Section I: PATIENT INFORMATION

Patient Name (last, first, middle initial):			
Birth date:	Social Security Number:		Medical Record Number:
Address:			
City:	State:	Zip:	Phone:

If you are not the patient, specify your relationship to the patient and the reason you are signing this consent for them:

RELATIONSHIP & REASON: _____

Section II: INFORMATION REQUESTED

I authorize _____ to use or disclose the following health information during the term of the Authorization:

Check all that apply:

☐ Patient visit notes	☐ Complete Medical Record
☐ Surgical *(operative report, path report)*	☐ Billing Records
☐ Hospitalization *(H&P, Consult, Tests, Surgical, Disch Summary)*	☐ Therapy Notes *(Specify: PT, Radiation, Chemo, etc.)*
☐ Test results *(Specify: Lab, Radiology Reports)*	☐ Chemotherapy Flowsheet ☐ Other

I fully understand that this release will include information relating to the testing, examination, diagnosis, treatment, and/or referral regarding the conditions listed below unless initialed by the signing party(ies):

_____ AIDS *(Acquired Immunodeficiency Syndrome)* or HIV *(Human Immunodeficiency)* infection
_____ Alcohol and/or drug use or dependence
_____ Mental health condition or developmental disability
_____ Sexually transmitted disease

Section III: RECIPIENT AND PURPOSE

Name of Person:	Phone Number:
Name of Organization:	
Street Address:	
City, State, Zip:	Purpose of Release:

I understand that I may inspect and have copies of the information I am releasing (according to NWOH policy) and that I may revoke at any time (except to the extent that NWOH has already acted on this consent to release medical records) by notifying the Medical Records Department at NWOH in writing that I am revoking this consent

I understand that the information identified above cannot be released unless I sign and date this consent form and that the stated purpose of the release may be in jeopardy if I do no allow the information to be released. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on signing this consent

I release NWOH from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by the recipient and this no longer protected under the HIPPA privacy rule

Signature _____ Date _____

Witness _____ Date _____

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