PACIFIC NORTHWEST UROLOGY SPECIALISTS PLLC

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AUTHORIZATION FOR PACIFIC NORTHWEST UROLOGY SPECIALISTS PLLC TO RELEASE OR OBTAIN HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

INFORMATION TO BE RELEASED **BY**:
❑ Pacific Northwest Urology Specialists
❑ _____
_____
_____
_____
Phone Fax

INFORMATION TO BE RELEASED **TO**:
❑ Pacific Northwest Urology Specialists
❑ _____
_____
_____
_____
Phone Fax

This request and authorization applies to:
❑ Entire medical record
❑ Other: _____
Excluding: ❑ Mental health records
❑ Communicable diseases (including HIV and AIDS)
❑ Alcohol/drug abuse treatment
❑ Other (please specify): _____

Purpose of Release:
❑ Continuing/Transfer of Care ❑ Insurance ❑ Litigation ❑ Personal Use ❑ Other _____

This authorization expires on the following date, event or condition: _____
If I do not specify any expiration date, event or condition, this authorization will expire in one year.
Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving a written notice to: Pacific Northwest Urology Specialists, PLLC, and Attn: Medical Records, 3232 Squalicum Parkway, Bellingham, WA 98225

Statement of Authorization:
- I understand that, except for research related treatment, Pacific Northwest Urology Specialists, PLLC will not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

*Patient or legally authorized individual signature: _____ Date signed: _____

***Under HIPAA you can be charged a "reasonable" fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.**

*Patient or legally authorized individual signature: _____ Date signed: _____

FOR PACIFIC NORTHWEST UROLOGY SPECIALISTS, PLLC USE ONLY

❑ Medical records released by: _____ Date: _____ ❑ Mail ❑ Fax ❑ Hardcopy ❑ Electronic

❑ Medical records requested by: _____ Date: _____