NORTHWEST FAMILY PHYSICIANS

HIPAA RELEASE OF INFORMATION AND DISCLOSURE FORM

Permission To Disclose Information To Those Involved In My Care
Either In Person, By Telephone, Voice Mail Message or Answering Machine Message

I hereby authorize:
Northwest Family Physicians to disclose my own protected health information in person, by telephone conversation, voice mail message, or answering machine message to the individuals and telephone number(s) listed below. I authorize the release of any of my protected health information, EXCEPT:

- ❑ Name
- ❑ Address
- ❑ Telephone Records
- ❑ Enrollment Information
- ❑ Claims Information
- ❑ Payment Information
- ❑ Managed Care Information
- ❑ Pharmaceutical Information
- ❑ Consultation Reports
- ❑ X-Ray Reports
- ❑ Discharge Summary
- ❑ Progress Notes
- ❑ Explanation of Benefits
- ❑ History and Physical Examination
- ❑ Laboratory Tests
- ❑ Complete Health Record(s)
- ❑ Other (please specify): _____

This authorization provides for use and disclosure of only that protected health information as provided on this form and only for the purpose of communicating medical information to/about me.

By signing below, I represent that I understand the following:

- I have the right to revoke this authorization at any time.
- I have the right to refuse to sign this authorization.
- That Northwest Family Physicians will not condition my treatment on whether I provide authorization for the requested use or disclosure.

By signing below, I authorize my physician to release my protected health information to/about me in person by telephone call, voice mail message or answering machine message to those listed below:

Those Authorized: ❑ Self Only ❑ Other _____

❑ Spouse _____ ❑ Parent(s) _____

❑ Child _____ ❑ Child _____ ❑ Child _____

Patient Names (Please Print) | Date of Birth | Today's Date

Signature | Telephone Number(s)