1593 E. Polston Ave
Post Falls, ID 83854
208-262-2300

AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION
All patient request's need to be in writing

Patient name_____

Date of Birth_____ Medical Record number_____

I hereby authorize the use or disclosure of protected health information as described below:

Specific information to be used or disclosed:

____complete copy	____discharge summary	____care plans	____h&p
____progress notes	____ekg	____consultation notes	____laboratory results
____discharge instructions	____orders	____radiology reports	____nursing notes
____rehab reports	____medication records	____radiology films	____immunization records
____treatment plans	____operative report	____pathology report	

I give special permission to release any information regarding:
____substance abuse ____psychiatric/mental health ____HIV information

Entity (ies) authorized to use or disclose the information: **NORTHWEST SPECIALTY HOSPITAL and its affiliated practitioners or employees.**

Entity (ies) to whom disclosure may be made: _____
Address: _____
_____

Purpose for use or disclosure: (check one)
_____ The use or disclosure is at the request of the individual.
_____ The use or disclosure is for marketing purposes. The health care provider will / will not (circle one) receive remuneration from a third party for the use or disclosure of information.
_____ other as described_____

This authorization will expire on the following date or event:
_____ One year from the date of the authorization **(maximum allowed)**
_____ Other as described_____

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by applicable law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that **NORTHWEST SPECIALTY HOSPITAL** may not condition my treatment on provision of the authorization unless the authorization is for the use or disclosure of information for research-related treatment, or unless the treatment is solely for the purpose of disclosing information to a third party (e.g., an employment physical).

I understand that I may revoke this authorization at anytime unless **NORTHWEST SPECIALTY HOSPITAL** has taken action in reliance on the authorization. To revoke the authorization, I must submit a written request to:

NORTHWEST SPECIALTY HOSPITAL
ATTN: PRIVACY OFFICER
1593 E. POLSTON AVE
POST FALLS, ID 83854

Signed by_____ Date_____

_____
(if signed by personal representative, describe authority)

The Medical Records Dept. may be reached at: phone 208-262-2305 fax 208-262-2382 5/20/13ss