Northwest Diagnostic

HIPAA
Authorization to Release Medical Information to Individuals/Family Members

Patient Name | Date of Birth

In accordance with federal government privacy rules implemented through The Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of Northwest Diagnostic Clinic to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. I understand that I may revoke this authorization in writing at any time.

Please initial one of the following:

_____ **I do not** authorize Northwest Diagnostic Clinic to release any or all information concerning my medical care or finances to any individual except as set forth above.

_____ I authorize Northwest Diagnostic Clinic to release any or all information concerning my medical care or finances to the following individuals via written, electronic, or verbal communication:

First and Last Name:	Relation to patient:	Date of Birth:

_____
Patient or Guarantor Signature

Date

Guarantor Name | Relation to Patient

**** I revoke all authorizations to the above named individual(s) effective immediately. ****

_____
Patient or Guarantor Signature

Date