NW WOUND SPECIALISTS
IN HOME WOUND CARE

NWWoundSpecialists@gmail.com

Medical Records Release

PATIENT INFORMATION		
LAST NAME	FIRST NAME	
EMAIL	PHONE	DATE OF BIRTH
ADDRESS		

Information to be Released:

- ☐ All Records
- ☐ History & Physical (Most Recent)
- ☐ Lab Reports
- ☐ Other: _____
- ☐ Records from Date Range: _____
- ☐ Recent Imaging
- ☐ Chart Notes

Reason for Request:

- ☐ Ongoing/Continuation of Care
- ☐ Other: _____

The above information may be released **to**:

NW Wound Specialists
NWWoundSpecialists@gmail.com

Requesting medical records **from:**

_____
Name of Person or Entity to Release Information

_____
Street Address

City, State & Zip Code

_____ _____
Phone # Fax #

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I do not have to sign this authorization in order to receive treatment from NW Wound Specialists. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to NW Wound Specialists. By signing, I authorize the release of information specified above.

_____ _____

Patient / Agent / Guardian Signature **Date** Relationship of Signer (If Other than Patient)