PLASTIC SURGERY
NORTHWEST

Release of Information

I________________________________, authorize the capture, disclosure, and use of photographs, video and accompanying protected health information related to my healthcare services at Plastic Surgery Northwest. I understand that my photo will be taken and placed in my permanent medical record. I understand that such photographs shall be retained for the purpose of public education, publication in visual media (including medical journals, textbooks, and presentations), PSNW website and/or social media and advertising.

I authorize Plastic Surgery Northwest, LLC to use and/or disclose the above-named individual's protected health information, including any and all documents containing information regarding any amendment of such information in the medical records as described below for the purpose of continuity of care for the period of ________________ to _________________.

Records to be disclosed:

☐ Comprehensive overview of chart from date:___________________ to ________________________.

☐ Images

☐ Other (specify type (required) – e.g. discharge summary, operative reports, billing records, lab reports.)

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I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not affect any actions taken prior to my revocation. If I do not revoke this authorization, it will expire 10 years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable confidentiality rules. If I have questions about the use or disclosure of my health information, I can contact Plastic Surgery Northwest at 509-838-1010.

*Please initial the below referenced information you wish to authorize.

______I hereby give my consent for Plastic Surgery Northwest Physicians or staff to leave information regarding my treatment, results, appointment information, or recommendations on my voicemail at the phone numbers I have provided.

______I hereby give my permission for Plastic Surgery Northwest Physicians or staff to phone me at my work.

______I hereby give my permission for Plastic Surgery Northwest Physicians or staff to discuss my billing, appointment, and caretaking information with the person/persons listed below:

Name____Relationship to Patient___________________________

Minors: A minor patient's signature is require in order to release the following information (1) conditions relating to the minor's reproductive care, (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older.)

I certify that I have read the about Authorization and Release and fully understand its terms.

____ ____________________________

Patient Signature *Date*