



NORTHWESTERN
HEALTH SCIENCES
UNIVERSITY

Authorization for Request of Medical Information

Patient:	Name: _____ Home Phone: _____ Previous name under which chart may be listed: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Social Security # _____ Date of Birth: _____ Age: _____ Treating Doctor's Name: _____
Health Care Provider:	Who has information you would like released? "Please fill out completely" Name: _____ Day Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
Requested By:	To Whom should the information be sent? "Please fill out completely" The Natural Care Center at Woodwinds NORTHWESTERN HEALTH SCIENCES UNIVERSITY (NWSU) 1875 Woodwinds Drive, Suite 100 Woodbury, MN 55125 (651) 232-6830
Information to be released:	Please select (X) all the choices that apply: ___ Complete X-ray films (including written results of MRI, CT, etc.) ___ Complete Medical Records (including Lab and X-ray reports, Patient Education Information, etc.) ___ Other (Specify) Records included will be for the last 24 months unless otherwise specified
Reason for Release:	<input type="checkbox"/> Insurance Change <input type="checkbox"/> Second Opinion <input type="checkbox"/> Move <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> Other _____
Disclosure Statements:	I understand that this authorization will be in effect for 12 months unless cancelled by me in writing. The cancellation will take effect when the provider receives my notice in writing. I understand that signing this authorization is voluntary. I understand that once information is disclosed by NWSU that the disclosed documents may no longer be protected by privacy laws.
Authorization:	I authorize the above provider to release the information marked above to the requestor: Patient Signature: _____ Date: _____ If other than patient, state relationship and reason patient cannot sign.