# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient Name:** _____
**Date of Birth:** _____ **Social Security #:** _____-____-_____

The above named person must indicate when this authorization is to expire:

☐ When information is received ☐ In one year

☐ In six months ☐ In three years

☐ On specified date _____

**The person named above is or has been a patient of:**

Provider/Facility: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

**The person named above hereby authorizes** _____ **to**

☐ Request health information from ☐ Send health information to

☐ Discuss health information with ☐ Release health information to

**The person named above authorizes information to be requested by representatives of**

Person/Provider/Facility: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

**Scope:**

☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____

☐ All information regarding care received by patient between specified dates:

Start Date _____ Ending Date _____

☐ Other information (specify): _____

**Authorization:**

_____
Printed name of patient or Authorized Representative

_____ _____ _____ _____
Signature of Patient/Representative Date Signature of Witness Date

If not signed by the patient, please indicate relationship of authorizing person to patient:

☐ Parent or legal guardian of minor child

☐ Guardian or conservator or conserved patient

☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above mush initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

| Initial | Date | | From | To |
|---|---|---|---|---|
| _____ | _____ | Alcohol or Drug Use/Abuse Treatment | _____ | _____ |
| _____ | _____ | Mental Health Treatment | _____ | _____ |
| _____ | _____ | HIV Status or Treatment | _____ | _____ |
| _____ | _____ | Medical Information/Treatment | _____ | _____ |
| _____ | _____ | Labs/Radiology Results | _____ | _____ |

**This record is requested for the following reason(s):**

□ Transfer of Care to (Provider Name): _____

□ Going to Specialist □ Insurance Purposes □ Personal Interest

□ Legal Purposes □ Other (specify) _____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be proved with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to your, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact a clinic office manager or site administrator for additional information about applicable copying fees.

| **I request and authorize:** | To release my records to: |
|---|---|
| Provider/Clinic: _____ | Family Practice by the Lake |
| Address: _____ | 1713 E Sherman Avenue |
| City: _____ State:_____ Zip: _____ | Coeur d'Alene, ID 83814 |
| Phone: _____ Fax: _____ | Phone: (208) 966-4087 |
| | Fax: (208) 966-4031 |