FAMILY MEDICINE HEALTH CENTER

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient First and Last Name: _____

Date of Birth: _____ Patient ID Number: _____

Address: _____

Telephone: (___) _____ Email Address: _____

Other names under which the Patient has been treated: _____

I authorize:

Name: _____

Address: _____

Phone #: _____ Fax: _____

Check one box only:

[ ] To release my confidential health information to: [ ] To request my confidential health information from:

Name: _____

Address: _____

Phone #: _____ Fax: _____

for the following purpose: (check one or more)

[ ] to provide treatment [ ] coordination of care [ ] at the request of the patient

[ ] marketing/fundraising [ ] other

I authorize PROVIDER and its employees, agents or associated healthcare practitioners to use or disclose the Patient's protected health information as described below.

[ ] treatment records [ ] lab tests

[ ] x-ray reports and other images [ ] history and physical evaluation

[ ] charges, payments, billing information [ ] accounting of visits

[ ] AIDS/HIV information [ ] other:_____

[ ] Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***

Healthcare provided between (*date*) _____ and (*date*) _____.

This authorization will expire on the following date or event: _____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

- I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:
  Family Medicine Health Center: 777 N Raymond St. Boise, ID 83704
- I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless the purpose for PROVIDER's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, the Patient is involved in research-related treatment and the use or disclosure is for such research.
- I understand that information disclosed by PROVIDER pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.
- I understand I may be charged if more than 15 pages are copied and that payment is due prior to release of records.

_____ _____

Signature Date

_____

Authority or relationship to the Patient

For Official Use Only.

Received: _____ Processed: _____ Amount: $_____