Lakeside Pediatrics and Adolescent Medicine

980 W Ironwood Drive Suite 302, Coeur d'Alene, Idaho 83814
Phone: 208-292-5437 Fax: 208-292-5441

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____
(Last) *(First)* *(Middle)*
Birth Date: _____ Phone: _____

Release From: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

Release To : Lakeside Pediatrics and Adolescent Medicine
980 W. Ironwood Drive, Ste. 302, Coeur d'Alene, ID 83814
Phone: 208-292-5437 **Fax**: 208-292-5441

Please check one of the following options:
( ) Patient will pick up and hand carry records
( ) Lakeside Pediatric will mail, fax, or email records to the individuals or organization above
( ) The individual or organization above will mail or fax records to Lakeside Pediatric

Information to be released:

Lakeside Pediatric & Adolescent Medicine, PLLC

Complete medical record: ☐ Most recent well child check: ☐

**Please list specific dates needed for requested information below:*

Laboratory: ☐ _____* Progress notes: ☐_____* Imaging: ☐_____*
Other:_____*

Restrictions and or Exclusions (If any): See disclosure statement below:
_____
_____

For the purpose of:
Transfer of Medical Care ____ Billing Purposes ____ Legal Matters _____Personal ____ Continued Care____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnoses, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed the information may not be protected by federal privacy laws and may potentially be disclosed by the recipient.
REVOCATION: I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Lakeside Pediatric and Adolescent Medicine in writing and by completing the REVOCATION OF AUTHORIZATION form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
EXPIRATION: This authorization will expire 6 months from date of signature.

Printed Name of Patient or Patient's Guardian:_____

Signature of Patient or Patient's Guardian: _____ Date:_____

Signature of Person Releasing Records: _____ Date: _____