Heather Stolworthy, MPH, MSN, FNP-C
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(208) 287-0408
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1000 N. Curtis Road, Ste. #105
Boise, ID 83706

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION PUSUANT TO 45 CFR 164.508

TO:

Heather Stolworthy FNP-C
1000 N. Curtis Road, Suite #105
Boise, ID 83706 Fax: 208-287-0423

RE:

Patient Name _____

Date of Birth _____

I authorize and request the disclosure of all protected information for the purpose and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All Physical, occupational and rehab requests, consultations and progress notes.

☐ All laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films, including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CD/films/reels and reports.

By signing below, I acknowledge the Authorization for Release of my Patient Information.

HIPAA COMPLIANT

Signature _____ **Date** ____ / ____ / ____
mm dd yy