Family Health Center

606 N. Third Ave. Ste. 101 Sandpoint, Idaho 83864 Phone: 208-263-1435 Fax: 208-263-4580
www.fhcsandpoint.com

Authorization To Release Medical Information

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

Requesting Records From: _____
City: _____ State: ___ Phone #: _____ Fax #: _____

Release/Send Records To: _____

Information to be released:

[ ] Last chart note
[ ] Last lab results
[ ] Last radiology report
[ ] Last year of complete chart record
[ ] Colonoscopy report & pathology
[ ] Transfer of Care

NOTE TO PROVIDER OFFICES: For transfer of care, please limit records to patient demographics, current medication list, problem list, last two office visits, most recent labs, most recent EKG, recent imaging reports, most current colonoscopy reports with pathology report, most recent echo, prior immunizations and any other information your practice feels is relevant to this patient's care. Thank you.

Purpose for which disclosure is being made: (Please check one of the following)
[ ] Attorney [ ] Doctor [ ] Insurance [ ] Personal [ ] Other_____

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

_____Drug/Alcohol abuse/treatment & diagnosis
_____Mental Illness or Psychiatric diagnosis/treatment
_____Sexually Transmitted Disease
_____HIV/AIDS diagnosis/treatment/testing

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed by this authorization. **There may be a charge for these copies.**

I understand that this authorization will expire 1 year from the date signed or on ___/___/___ (MM/DD/YY). **Initial** _____

I understand that I may revoke this authorization at any time by notifying Family Health Center in writing, but if I do it will not have any affect on any actions Family Health Center took before they received the revocation.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

_____ _____
Signature of Patient or Patient Representative Date

*Please provide documents to prove authority to sign on behalf of the patient.