River Horse Medical Clinic, PLLC
Jennifer Grinage, PA-C
Secure Fax: 208-616-1453

Authorization to Release and/or Disclose Protected Health Information

Patient Information:

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ Former Name(s) Used: _____

Address: _____
(Street and/or PO Box #) *(City)* *(State)* *(Zipcode)*

Preferred Phone: _____ Okay to leave message? ☐ Yes ☐ No

Release From:	**Release To:**
Person/Organization: _____	___River Horse Medical Clinic, PLLC_____
Address/Attention To: _____	___Jennifer Grinage, PA-C_____
Phone/Secure Fax: _____	____**208-616-1453**_____

Purpose/Reason(s) for Request:

☐ Continuity of Care ☐ Employment Related ☐ Insurance ☐ Disability
☐ Legal ☐ Adoption ☐ Personal ☐ Other _____

Information to be Released:

☐ Progress Notes & Consults ☐ Hospital Admit/Discharge ☐ Surgical & Operative Notes ☐ ED Visit Notes & Test Results
☐ Radiology Reports ☐ Laboratory Results ☐ Immunization Record ☐ Billing Summary
☐ Ongoing Disclosure for Billing & Scheduling Purposes ☐ Other: _____
☐ Entire medical record for the last 2 years plus all imaging reports for the last 10 years.

Explicitly Protected Health Information: *(MUST check one of the below boxes)*

☐ Include **complete records** (without redaction) including records that may contain information regarding the testing, diagnosis, or treatment of the following: substance use or abuse disorders, behavioral or mental health, genetic testing, sexually transmitted diseases, and Acquired Immunodeficiency Syndrome (AIDS).

☐ Please redact/block out information containing testing, diagnosis, or treatment of the following: substance use or abuse disorders, behavioral or mental health, genetic testing, sexually transmitted diseases, and Acquired Immunodeficiency Syndrome (AIDS). **I understand that this is a manual process and may take additional time to process this request.**

Dates of Services/Treatment Dates:

☐ This release covers medical records from _____ to _____
☐ All Treatment Dates ☐ Future dates (ONLY for disclosures to family/caregiver) through_____*(date)*

Format/Delivery Method:

☐ US Mail ☐ Patient Portal *(if available)* ☐ Pick-Up in person or by authorized individual _____
☐ Email _____ ☐ CD ☐ Phone *(Example: Caregiver or Family involved in care)*

Records sent by email or CD must be encrypted in accordance with federal regulations unless the patient or authorized representative requests information to be sent in an unsecured format. **If you would prefer electronic communication without encryption, please specify below by initialing.** Your information will be sent without encryption & may be at risk.

☐ I prefer to have requested information sent unsecured. I understand and accept the risk. **INITIALS:** _____

I understand that I may refuse to sign this authorization and it will not affect my ability to receive care. I understand that I may revoke this authorization in writing at any time by notifying the above "Released From/To" party. I understand that I may inspect or copy the information to be disclosed in this authorization. I understand that if the information covered in this release is disclosed to an entity not covered under federal privacy regulations, the information is no longer protected by said regulations. I understand that if I do not specify an expiration date, this authorization will expire in 90 days.

Patient/Authorized Representative Signature: _____ **Date:** _____

Relationship to Patient: _____ **This Authorization Expires on:** _____*(date)*