**Crosspointe Family Services**

**1363 Fillmore St, Twin Falls, ID 83301**

**Office: (208)-736-7090 Fax: (208)-736-7089**

**MEDICAL-Release and/or Exchange of Protected Health Information**

Patient Name: Date of Birth:

Parent/Guardian Name:

**I DECLINE TO RELEASE ANY INFORMATION TO:**

**I authorize:**

Name/Title:

Address: City: State: Zip:

Phone: ( ) Fax: ( )

***(Initial either or both as needed.)*  to release PHI information to: to obtain PHI information from:**

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**A. The confidential Protected Health Information (PHI) to be released: (Initial)**

History and Physical Laboratory Results Coordination of Care Communication

Last Office Progress Note Pharmacy/Medication List Entire Medical Record

Progress Notes: from\_\_\_\_\_ to \_\_\_\_\_ Medication List(s) Parent/Guardian Communication

Discharge Summary Comprehensive Diagnostic Assessment Care Plan

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this “Release of PHI” is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

**B. Effective date of authorization:**

This authorization takes effect the day that you sign it and terminates on: or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

Participant/Guardian Signature Date Witness Signature Date