PCS
PRIMARY CARE SPECIALISTS

Authorization to Use and/or Disclose Health Information

Patient Name: _____ (Please note any other variations in name i.e.: maiden names)

DOB: _____ SS# _____

Address: _____

Complete Transfer of Care: _____ yes or _____ no

(Please circle either from & to) (Please give complete names & addresses)

From / To: _____

_____

Phone: _____ Fax: _____

From / To: Primary Care Specialists 110 Vista Drive Pocatello, Idaho 83201

Phone# (208) 234-2300 Fax# (208) 234-0026 Email: sara@pcspocatello.com

I authorize the use and/or discloser of the above listed patient health information for the following purpose(s): [describe each purpose: if requested by patient and if no purpose is identified, then may state "at the request of the individual"]

_____

By initialing the space below, I specifically authorize the use or disclosure of the following information and/or records, if such information and/or records exist:

_____ All Records generated by this office from 1st DOS to last. (By initialing this box, you are agreeing to release: HIV/AIDS related health information and/or records, genetic testing information and/or records, drug/alcohol diagnosis, treatment and/or referral information, behavioral/psychology and/or records.)

OR

_____ Other - Please Specify _____

Date Range: _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Primary care Specialists, PA. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so. (A copy of this signed form will be provided to the individual's legal representation upon request)

Date: _____

Signature of Individual or Individual's Legal Representative _____

Print Name of Legal Representative (if applicable) _____