Bonners Ferry Family Medicine

Medical Records Request

Patient name: _____ Date of birth: _____

Address: _____ Phone: _____

*Please circle where the records are coming **"FROM"** and where they are being released **"TO"***

To	From	To	From
Bonners Ferry Family Medicine 6488 Chinook St Bonners Ferry, ID 83805		Name of Healthcare Provider or Facility: _____ Address:	
Phone: 208-267-8710		Phone:	
Email: bffmtg@protonmail.com		Fax:	
Fax: 800-540-3198			

If the records you are sending are more than 20 pages, please mail or email, as our fax system will not accept more than 20 pages at a time. Thank you

To Release:

- ☐ Most current medical history (up to the last 2 years, unless otherwise stated)
- ☐ Labs & Image reports only
- ☐ Only these records (specify): _____
- ☐ Only records dated from: _____ to _____

For The Purpose Of:

- ☐ Adjunctive/Concurrent Care
- ☐ Transfer Care
- ☐ Other _____

*The following items **will be included** in records unless initialed.
*HIV/AIDS/STD-related records_____
*Mental Health information_____
*Genetic testing information_____
*Drug/alcohol abuse/dependency diagnosis, treatment, or referral information_____

This authorization is valid for sixty (60) days from the date signed. I can cancel this authorization at any time by writing to BFFM unless disclosure has already occurred in compliance with this consent. I understand that authorizing the disclosure of this health information is voluntary. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws, and may potentially be re-disclosed by the recipient. I can refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment. **There may be a charge for these copies.**

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____