



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: _____	
Fax: 888-972-7960		Fax: _____	

If the records you are sending are more than 20 pages, please mail, as our 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: _____