Lakeside Pediatric & Adolescent Medicine, PLLC

980 W Ironwood Drive Suite 302
Coeur d'Alene, Idaho 83814
Phone: 208-292-5437 Fax: 208-292-5441

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patients Name: _____
(Please print) *(Last)* *(First)* *(Middle)*

Birth Date: _____ Soc Sec#: _____ Phone: _____

Release From: _____ Release To: _____

_____ _____
_____ _____
_____ _____

Phone: _____ Phone: _____
Fax: _____ Fax: _____

Please check one of the following options:

( ) Patient will pick up and hand carry records
( ) Lakeside Pediatric will mail or fax records to the individuals or organization above
( ) The individual or organization above will mail or fax records to Lakeside Pediatric

Information to be released:

Most recent well child check: ____ Laboratory:____
Progress notes:____ Complete medical record:____
Imaging:____ Other:_____
Restrictions and or Exclusions (If any): See disclosure statement below
_____
_____

For the purpose of:
Transfer of Medical Care ____ Billing Purposes ____ Legal Matters _____Personal ____ Continued Care____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnoses, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed the information may not be protected by federal privacy laws and may potentially be disclosed by the recipient.

REVOCATION: I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Lakeside Pediatric and Adolescent Medicine in writing and by completing the REVOCATION OF AUTHORIZATION form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

EXPIRATION: This authorization will expire 6 months from date of signature.

Printed Name of patient or patient's guardian:_____

Signature of patient or patient's guardian: _____ Date: _____

Signature of person releasing records: _____ Date: _____