Authorization for Release of Immunization Information

Boise, ID 83704 / Phone: 208-327-7400 / Fax: 208-327-8579

Last Name	First Name	MI

Former Name(s) if applicable	Telephone	DOB (/ /)

Address	City	State	ZIP

Delivery of Information

Please mark below how you would like this information delivered to you. ** Telephone requests are not allowed.

☐ Mail my record to address other than above: _____

_____

☐ Fax my copies to Physician/Clinic/School listed below

☐ Fax my copies to CDHD – Boise Office

☐ Fax my copies to CDHD – Mt Home Office

☐ Fax my copies to CDHD – McCall Office

☐ Fax the information to:
Attention: _____

Fax number: _____

☐ I will pick up my records. Please bring ID

Physician/Clinic/School			
Address	City	State	ZIP
( )	( )		
Telephone	Fax		

Physician/Clinic/School			
Address	City	State	ZIP
( )	( )		
Telephone	Fax		

Consent

I understand that my medical record may contain personal or sensitive information. Release of this information is voluntary and protected by law. The facility, its employees, officers, and contracting physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I specifically authorize the disclosure and release of the following information to the persons/clinic indicated above if I check **yes** in the box (IDAPA 16.05.01 Protection and Disclosure of Department Records, Public Health Act Section 523-527).

☐ Yes ☐ No Provide authorization to fax my medical records for release or disclosure of the information above. (IDAPA 16.05.051)

**I understand telephone requests will not be honored. Requests must be made in writing by using the Authorization for Release of Information. I understand that I may revoke this authorization at any time. If I do not, it will be valid for 24 months from the date I sign it.

Client Signature	**Date**

Signature if Other Than Client	**Legal Relationship to Patient**	**Date**