Authorization for Release of Information

Last Name First Name MI

Former Name(s) If applicable (/ /) DOB

Address City State Zip

Reason for Request: ❑ Continuation of Care ❑ Other/ Billing ❑ Other/ Insurance

Specific Information Requested:

❑ Lab Reports - within last six months ❑ Physical - most recent exam

❑ Pathology Reports-(***1 yr. if within normal limits; last 3 yrs. if abnormal)***

❑ Medical Imaging - within last year ❑ Immunizations

Transfer Copies of My Medical Records From (Please print clearly):

Physician and/or Clinic

Address City State Zip

( ) - ( ) -

Telephone Fax

Please Send Copies of My Medical Records To (Please print clearly):

Physician and/or Clinic

Address City State Zip

( ) - ( ) -

Telephone Fax

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 All my medical records or other information regarding my treatment, history, tests, diagnosis, or treatment relating to sexually transmitted disease(s). (Federal Regulation 42 CRF Part 2)

❑ Yes ❑ No Information from my history, tests, diagnosis, or treatment relating to HIV or AIDS.

❑ Yes ❑ No Specifically authorize the medical center to release records of alcohol and drug abuse treatment protected under Section 333 of the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1980 and Section 408 of the Drug Abuse Office and Treatment Act of 1972, and psychiatric or psychological care or examination.

❑ 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**