**AUTHORIZATION TO ACCESS, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other names under which\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**patient has been treated**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CURRENT PHONE#: Cell# \_\_\_\_\_\_\_\_\_\_\_\_\_Home#\_\_\_\_\_\_\_\_\_\_\_\_**

**RECORDS RELEASED FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician/Medical Office**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City State Zip Phone/Fax**

**TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City State Zip Phone/ Fax**

**I hereby authorize and request the release of the following information:**

**\_\_\_\_\_\_\_Patient information for visit date(s) from\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_Specific records –\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose for release of information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHOOSE ONE FORMAT FOR RECEIVING THE INFORMATION: Paper mail \_\_\_\_\_\_Electronic Copy \_\_\_\_\_\_**

**Fax \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or \*\*HIV test results, if any, except as specifically provided below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If not signed by the patient, please indicate relationship: Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] parent or guardian of minor patient (to the extent minor could not have consented to the care)

[ ] guardian or conservator of an incompetent patient

[ ] beneficiary or personal representative of deceased patient

[ ] spouse or person financially responsible (where information solely for purpose of processing application for defendant health care coverage)

I may revoke this authorization in writing at any time by writing to Idaho Gastroenterology at 425 West Bannock Street, Boise, Idaho 83702 attention medical records. I understand that the revocation will not apply to information that has already been released. I understand that this authorization for release of information is voluntary. I can refuse to sign this authorization and know that I do not need to sign to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimiles of this authorization shall be the same as a signed original document.

**This authorization expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (OTHERWISE WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED**

R2022