IDAHO GASTROENTEROLOGY ASSOCIATES, LLP

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME:_____MAIDEN/PRIOR NAME_____

DATE OF BIRTH:_____LAST FOUR SS#:_____ CURRENT PHONE#:_____

RECORDS RELEASED FROM:_____
Physician/Medical Office
_____
Address
_____
City State Zip

TO: _____
Name
_____
Address
_____
City State Zip Phone

*****PLEASE CHECK ALL THAT APPLY**

*****I PREFER TO HAVE THESE RECORDS: Picked up_____ Mailed_____ Shared by Phone_____**

I hereby authorize and request the release of the following information

_____Patient information for visit date(s) from_____ to_____

_____Specific records –_____ _____

WE WILL NOT SEND RECORDS TO THIRD PARTIES WITHOUT REQUEST/AUTHORIZATION FROM THAT THIRD PARTY.

Purpose for release of information:_____

This authorization expires on: _____(If no date is specified, this authorization will expire in 12 months)
If you do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and or alcohol abuse, mental illness or psychiatric treatment, please initial here _____. **Unless initialed here this information is deemed permissible to release.**

Upon request, I may limit the amount of time this consent for release of information is valid. 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 considered to be the same as a signed original document.

SIGNATURE:_____DATE_____

Relationship to patient (If parent or guardian): _____