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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** _____

As the patient, you agree that all medical records will be released unless you have specifically requested that the following sensitive information not be released. Please circle the information you wish to be withheld:

HIV Status

Mental Health

Drugs and Alcohol Use

Signature: _____ **Date:** _____

If not signed by the patient, please indicate relationship: **Print Name:** _____

- ☐ Parent of 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 of 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)**