Authorization for Release of Protected Health Information

To be completed by the patient or the patient's authorized representative:

_____ _____/_____
Patient's Name *Patient's SSN* *Patient's Date of Birth*

_____
Street Address

_____ _____
City *State* *Zip Code* *Telephone*

I hereby authorize the below referenced provider to release confidential and protected health information, as described below:

_____
Name
Idaho Physical Medicine and Rehabilitation PA
Organization Name
P.O. Box 1128
Street Address
Boise Idaho 83701
City *State* *Zip Code*
208-489-4016
Telephone
208-489-4015
Fax

I hereby authorize the following person or organization to receive this information:

_____
Name
_____
Organization Name
_____
Street Address
_____
City *State* *Zip Code*
_____
Telephone
_____
Fax

Specific Information to released/disclosed is as follows:

___ patient information for visits of Idaho Physical Medicine and Rehabilitation PA providers
___billing records - statements of charges and payments
___specific Lab/x-ray/Report:_____
___ **All records, or related to the period:** _____ **and** _____
(from) (to)

If you **do not** wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and or alcohol abuse, mental illness or psychiatric, please initial here _____. **Unless initialed here this information is deemed permissible to release.**

This authorization is valid for 180 days, unless revoked or expires on: _____
(Expiration Date)

Notice to Patient:

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at IPMR. You do not have to sign this authorization and that your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original.

_____ _____
Patient's Signature Date Print Patient's Name

_____ _____
Signature of Parent or Personal Representative Date Print Personal Representative Name

I PREFER TO HAVE THESE RECORDS: ☐ FAXED ☐ MAILED ☐ PICKED UP AT _____
(CLINIC)