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 <u>to release</u> confidential and protected health information, as described below:

____
Name

____
Organization Name

____
Street Address

____
City *State* *Zip Code*

____
Telephone

____
Fax

I hereby authorize the following person or organization to <u>receive</u> this information:

____
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

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 <u>**do not**</u> 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)

<u>Notice to Patient:</u>

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)