WEST IDAHO ORTHOPEDICS & SPORTS MEDICINE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

206 E. Elm ST. Caldwell, ID 83605 Phone: 208-459-4511 Fax: 208-459-6602
3875 E. Overland Rd. Meridian, ID 83642 Phone: 208-895-0888 Fax: 208-888-3911

Patient Name _____ Date of Birth _____

Previous Name(s) _____

I authorize West Idaho Orthopedics to use or disclose Protected Health Information (PHI) contained in my medical records in the following manner:

From _____
Physician/Institution that currently has records

_____
Street Address

_____
City State Zip Phone Fax

To _____
Physician/Institution/Individual requesting records

_____
Street Address

_____
City State Zip Phone Fax

Release the following Protected Health Information *(Patients who request more than the last 2 years of their records may be charged a $10 service fee. All payments are required prior to copying. All records are burned to a CD, faxed or emailed. If paper copies are requested, there will be additional charges.)*

☐ All Records ☐ Operative Report(s)

☐ X-Ray / Diagnostic Report(s) ☐ Labs / Pathology Reports(s)

☐ Chart Notes ☐ Medical Bills

☐ Discharge Summary ☐ Other _____

Reason for Authorization _____

Expiration ☐ Date _____ OR ☐ Event (one-time release) _____

☐ Pick up Location _____ ☐ Faxed ☐ Mailed ☐ E-Mailed to _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment, or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized West Idaho Orthopedics to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to West Idaho Orthopedics, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked NO and initialed it. _____ YES _____ NO _____ INITIALS

_____ _____ _____
Signature/Legally Responsible Party Relationship to Patient Date