WEST IDAHO ORTHOPEDICS & SPORTS MEDICINE

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AUTHORIZATION TO RELEASE Protected Health Information (PHI) RECORDS

REQUEST TO RELEASE OF PHI TO WEST IDAHO ORTHOPEDICS: Caldwell, Meridian, Emmett, Fruitland
206 E. ELM ST. CALDWELL, ID 83605 PHONE: 208-459-4511FAX: 208-459-6602
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**** PLEASE NOTE – IF THE RECORDS ARE OVER 30 PAGES, PLEASE SEND VIA US MAIL RATHER THAN FAXING***

PATIENT NAME: _____ DOB: _____
At the request of the above identified person, this is to authorize the release of PHI records.

Purpose or need for release of PHI:_____

RELEASE OF PHI RECORDS FROM THE FOLLOWING: (Please check all that apply)

{ } PROVIDER NAME: _____
PHONE:_____ FAX #:_____
ADDRESS:_____CITY_____STATE:_____ZIP:_____
{ } OTHER: NAME OF PERSON OR ENTITY: _____
ADDRESS:_____CITY_____STATE:_____ZIP:_____
PHONE:_____ FAX #_____

PHI RECORDS TO BE DISCLOSED: (Please check all that apply)

{ } ALL MEDICAL RECORDS
{ } History and Physical
{ } Discharge Summary
{ } Operative Report(s)
{ } Pathology Report(s)
{ } X-Ray Report
{ } Physician's Orders and Progress Notes
{ } Nurse's Notes
{ } Emergency Room Record
{ } Outpatient Surgery
{ } Medical Bills
{ } Other _____

{ } Alcohol or Drug Abuse Records
(patient must initial _____to be valid)
{ } AIDS Diagnosis and/or Positive HIV Tests
(patient must initial _____ to be valid)

This authorization is valid for one year unless revoked in writing.

Date: _____ Signature: _____
A copy of this document shall have the same effect as its original Individual or Personal Representative
Description:_____

Records obtained as authorized by this consent for information release will be maintained in accordance with the Federal Confidentiality regulations (Title 42 of the Federal Register) which prohibits re-disclosure except with the specific written consent of the person to whom it pertains.