Release of Information Form: Please fill out and return to our office if you wish us to obtain or disclose information about your care

R072716

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____**DOB**_____

I hereby authorize (*name of your provider*) _____ **and his or her employees to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.**

☐ Obtain information from: AND/OR ☐ Disclose information to:

Name and Address:_____

_____Phone #:_____

Category and Time Period of PHI

Please initial the Category of PHI you wish to release

☐ Initial Evaluation ☐ Claims/Billing Information ☐ Lab Results ☐ Medication List

☐ Progress Notes ☐ Therapy notes ☐ Entire Medical Record ☐ Appt. Scheduling & Info.

☐ other_____

Time period of healthcare treatment records you wish to be included:

☐ Anytime ☐ Healthcare provided between (date)_____ and (date) _____

Limit of PHI

I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated below by initialing the appropriate category of PHI I *DO NOT* wish to be released.

_____ HIV/AIDS test results or diagnosis _____Alcohol/drug abuse _____ Other_____

Please limit the use and disclosure of my PHI to only include the following dates:_____

[Example: laboratory results from July 1998; mental health records from January 2001 to present"]

Purpose of PHI

☐ Continuity of Care ☐ Aftercare Planning

☐ Contact with Referring Supervisor ☐ Referral

☐ Family Involvement ☐ Other_____

I understand that this authorization will expire on the following date or event:_____
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not effect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 413 N Allumbaugh Street, Suite 101, Boise, ID 83704

Signed:_____Date:_____

If not signed by the patient, please indicate authority or relationship:_____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.