



176 Falls Ave
Twin Falls ID 83301
Phone 208.733.3181
Fax 208.733.3168

SOUTHERN IDAHO PAIN INSTITUTE
Improving Quality of Life

Authorization to Disclose Protected Health Information

This form is for all record requests.

NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

RELEASE INFORMATION FROM:

Specify Provider/Organization or Person Name and Address

Organization Name: _____

Other: _____

Address: _____

Phone: _____ Fax: _____

RELEASE INFORMATION TO:

Specify Provider/Organization or Person Name and Address

Organization Name: _____

Other: _____

Address: _____

Phone: _____

Fax: _____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME: _____ **Phone Number:** _____

MAIDEN OR OTHER NAME: _____

DATE OF BIRTH ___/___/____ **SSN/MEDICAL RECORD #** _____

ADDRESS _____

Mailing Address, City, State, Zip

Covering the period(s) of health care:

FROM (Date) ___/___/____ **TO** (Date) ___/___/____

1. Information authorized for disclosure, if included in my records:

- Complete Health Record
- Visit/Discharge Summary
- Clinical Documentation of Physical
- Documentation of Consultation
- Progress Reports
- Radiology and Diagnostic Imaging Reports
- Photographs, Digital or Other Images
- Laboratory test *(please specify)* _____
- Other *(please specify)* _____

<Continued on Back>

2. **If applicable, I also give permission** for the following “Sensitive Protected Health Information” to be disclosed (**please initial below**):
- o Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
 - o Behavioral Health Services/Psychiatric Care
 - o Treatment for Alcohol and/or Drug Abuse
 - o Sexually Transmitted Diseases (STD)
 - o Genetic Counseling/Testing

_____ **I understand** that the information disclosed pursuant to the Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. **The purpose for which disclosure is authorized** (check where applicable):

Medical Care Insurance Benefit eligibility Immunization

Other: _____

4. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date (expiration date, if any ___/___/____), event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here _____) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

5. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have question about disclosures of my health information, I can contact my provider of care.
6. This facility, its employees, officers, and physicians are hereby releases from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: Patient – (or Legal Representative, Parent, or Legal Guardian)

(Relationship if not Patient)

ID Provided _____

Date ___/___/____

Witness Signature