

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO A FAMILY MEMBER OR FRIEND**

RELEASE FROM:

T.S. ROOSEVELT, M.D., Ph.D.
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9196 W. EMERALD ST. SUITE 160
BOISE, ID 83704
PHONE: (208) 389-2213

Patient Information

Name: _____

Address: _____

Phone: _____ Birthdate: _____ SS#: _____

Person to Receive Information:

Name: _____

Relationship to patient: _____

Phone: _____

_____ This request is for all medical records.

_____ This request is for specific reports: (Please circle which reports)

Labs X-rays Office Notes Hospital Records

Patient Signature: _____

Parent or Legal Guardian: _____

Relationship to patient: _____ Date: _____

**THE ORIGINAL MEDICAL RECORD IS THE PROPERTY OF IDAHO DIABETES AND
ENDOCRINE ASSOCIATES. A MINIMUM FEE MAY BE CHARGED FOR RECORDS GIVEN
TO THE PATIENT OR FORWARDED TO ANOTHER MEDICAL FACILITY.**

THERE IS A MINIMUM 48 HOUR WAITING PERIOD.

****THIS RELEASE EXPIRES ONE YEAR FROM DATE SIGNED.****