IDAHO DIABETES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name: _____Date of birth: _____
Address: _____ Phone: _____

I authorize my medical records to be released:

TO/FROM (circle one):
Idaho Diabetes and Endocrine Assoc.
13909 W. Wainwright Drive
Boise, ID 83713
Phone: (208)389-2213
Fax: (208)389-4659

TO/FROM (circle one):
Name: _____
_____
Address: _____
_____
Phone: _____
Fax: _____

Purpose for the medical records release:_____
This authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event this authorization will expire 1 yr from the date signed.

The following information is authorized for release:

☐ All records ☐ Recent Visit/Notes ☐ Laboratory Reports ☐ Radiology Reports ☐ Operative Reports ☐Pathology Reports
☐ Other: _____

I understand the information in my health record may include information relating to substance abuse, mental health information, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and sexually transmitted disease. My signature below authorizes release of all such information.

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirement. Idaho Diabetes and Endocrine Associates, its employees and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization. I know I may revoke this authorization to the extent that it has not already been relied upon. I may revoke this authorization by writing a statement that I withdraw my authorization for further release of my records. I understand that the disclosure of this health information is voluntary. I do not need to sign this form to assure treatment unless the sole purpose of the treatment/examination/evaluation is to provide information to a third party. I have a right to receive a copy of this authorization.

Patient signature: _____ Date: _____
Parent/Legal Guardian/Patient representative: _____
Printed name of parent/legal guardian/representative: _____