Eagle Creek Family Medicine

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AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME ____________________   DATE OF BIRTH ____________

ADDRESS ____________________   PHONE NUMBER ____________

CITY ____________ STATE ________ ZIP ________   E-MAIL ____________

I hereby request that a copy or summary of my records, INCLUDING LABORATORY or X-RAY reports that you may have which contain information relevant to my present and future diagnosis and/or treatment be released.

TO: ______________________________   FROM: ______________________________

______________________________   ______________________________

______________________________   ______________________________

SPECIFIC AUTHORIZATION

Substance Abuse	Mental Health	HIV (AIDS)	○ **AT MY REQUEST**
Treatment Information	Test Results	**All Records**	○ **Other**______________

I acknowledge that data to be released may include material that is protected by federal law and that is applicable to ANY or ALL of the above. My signature below authorizes release of all such information except as otherwise specified.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization from:

- To take part in a research study.
  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Eagle Creek Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

______________________   ______________   __________
Patient or legally authorized individual signature   Date   Time

______________________   ______________________________
Printed name if signed on behalf of the patient   Relationship (parent, legal guardian, personal representative, etc.

____
Witness Signature

PLEASE MAIL OR FAX TO:

Eagle Creek Family Medicine
1281 E Iron Eagle Drive
Eagle, ID 83616

Phone: (208) 939-5535
Fax: (208) 939-5536