STEELE MEMORIAL MEDICAL CENTER

203 S DAISY ST ~ SALMON, IDAHO 83467 ~ (208)756-5600 ~ FAX (844) 259-7221

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

I hereby authorize (**Organization or Provider Name):** _____

Address: _____ **City:** _____ **State:** _____

Phone: _____ **Fax:** _____

To disclose the following information from the health records of:

Patient Name: _____ **Date of Birth**:_____

Address: _____ **Phone**: _____

Other names the patient is known by or has been treated: _____

Requesting Health Care Records Occurring during these Dates/Period(s): From:_____ **To:** _____

- ☐ Anesthesia Record
- ☐ Cardiopulmonary ☐ PFT ☐ EKG
- ☐ Consultation Notes
- ☐ Demographic Information
- ☐ Discharge Summary
- ☐ Discharge/Patient Instruction
- ☐ Doctor's Orders
- ☐ Emergency Room Notes
- ☐ History & Physical Note
- ☐ Immunizations
- ☐ Imaging/X-ray Reports
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Medication List
- ☐ Nurse Notes
- ☐ Operative Report
- ☐ Physician/Provider Progress Notes
- ☐ Phys/ Occ/ Resp/ Speech Therapy Notes
- ☐ Other: _____

I understand that this will include information relating to (check if applicable)

- ☐ Acquired Immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
- ☐ Behavioral health services / psychiatric care (excluding psychotherapy notes)
- ☐ Treatment for alcohol and/or drug abuse

I authorize this information to be disclosed to: **Steele Memorial Medical Center**
203 S Daisy St
Salmon, ID 83467
Fax: 844-259-7221

Purpose of Disclosure: _____

☐ At the request of the patient ☐ For potential or pending legal proceeding ☐ Personal Use ☐ Continued Patient Care

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- I understand that if protected health information is disclosed to those not required to comply with the federal privacy protections, such information may be re-disclosed and would no longer be protected.
- I understand that I have the right to revoke this authorization at any time except to the extent that Steele Memorial Medical Center has taken action in reliance on this authorization.
- To revoke this authorization, I must submit a written revocation to: Steele Memorial Medical Center.
- ***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 may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may inspect or copy any information used/disclosed under authorization.

SIGNED: _____ **DATE:** _____
(Patient or personal (legal) representative to patient)

Relationship of personal (legal) representative to patient: _____

WITNESSED BY:_____ **DATE:** _____

INFORMATION RELEASED BY: _____ **DATE:** _____

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