STEELE MEMORIAL MEDICAL CENTER

203 S. DAISY ST. ~ SALMON, IDAHO 83467 ~ (208)756-5600 ~ FAX (208) 756-4169
Risk Management/HIPAA ~ (208) 756-5726 ~ Fax: Health Information Management (208) 756-5829

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Steele Memorial Medical Center to disclose the following information from the health records of:

Patient Name:_____Date of Birth: _____

Address:_____

Telephone:_____ Medical Record Number:_____ **Circle One:** Hospital or Clinic Record

Other names under which the patient has been treated: _____

Covering the Dates/Period(s) for Health Care Occurring: From: _____To:_____

□ Prescription	□ Discharge Summary	□ Physical Therapy Notes
□ Chart Notes	□ Doctor's Orders	□ Physician/Provider Progress Notes
□ Demographic Information	□ Emergency Record	□ Respiratory Therapy Notes
□ Pathology Reports	□ Emergency Room Note	□ Speech Therapy Notes
□ Radiology Reports	□ History / Physical	□ Medication Record
□ Laboratory Reports	□ Cardiopulmonary □PFT □ EKG	□ Nurses Notes
□ Occupational Therapy Notes	□ Discharge/Patient Instruction	□ Anesthesia Record
□ Consultation	□ Operative Report	□ Itemized Statement
□ UB-92 (Billing Forms)	□ HCFA Forms (Billing Forms)	□ 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 psychotheraphy notes)
□ Treatment for alcohol and / or drug abuse

I authorize this information to be disclosed to the following Organization(s) or Individual(s) for the following purpose:

Organization or individual(s): Name _____

Address(s):_____

Purpose of Disclosure:_____
□ At the request of the individual.
□ For a potential or pending legal proceeding.

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:_____

Form: 660-005a
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