AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name ____________________________________ Birth Date ____________________

Address ____ Phone # ________________

This is to authorize the described medical records regarding the above patient to be released by:

Minidoka Memorial Hospital
1224 8th Street
Rupert, ID 83350

Records to be released to:

Facility/Provider receiving records ____

Address ____

Phone # ____________________ Contact Person _________________________________

Describe purpose or need for records ____

Description of Information requested: (check all that apply)

- ☐ All Records
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ X-Ray Report/Images
- ☐ Physician's Orders and Progress Notes
- ☐ Emergency Room Record
- ☐ Pathology/Lab Report
- ☐ Alcohol or Drug Abuse Records (must initial to be valid ________)
- ☐ Other ________________________________

This authorization is valid for six months from the date signed.

This authorization may be revoked at any time, in writing. For instructions on how to revoke this authorization, please refer to the hospital's "Notice of Privacy Practices".

Treatment or payment may not be conditioned upon our receipt of authorization.

Releasing medical information as a result of this authorization may mean that your medical information could be re-released by the recipient and no longer protected by Federal Privacy Rules.

Signature ____ Date __________________

Signature of Personal Representative ________________________________ Date __________________

State relationship and reason for signing (patient is incompetent, minor, etc.) ______________________

Witness ____ Date__________________

Information requested released by ____________________________________ Date__________________

Indicate method: ☐ copy to patient ☐ mail ☐ fax ☐ other ______________________________