Minidoka Memorial Hospital

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 _____

Dates of Service Requested: _____

Description of Information requested: (check all that apply)

All Records	X-Ray Report/Images
History & Physical	Physician's Orders and Progress Notes
Discharge Summary	Emergency Room Record
Operative Report	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.) _____

Information requested released by _____ Date_____

Indicate method: copy to patient mail fax other _____