# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION


**McMillan Medical Center**
**4750 N. Five Mile Rd.**
**Boise, ID 83713**
**(208) 375-0500**
**Fax (208) 375-4310**

**Ustick Medical Center**
**10787 W. Ustick Rd.**
**Boise, ID 83713**
**(208) 853-3100**
**Fax (208) 853-3120**


(Please note this form must be 100% complete to be valid)

**Patient Name: _____Date of Birth _____ SS# _____**

I authorize McMillan Medical Center/Ustick Medical Center to use or disclose the Protected Health Information contained in my medical record in the following manner:

**FROM:_____PHONE: _____FAX:_____**

**TO: _____PHONE:_____FAX:_____**

**RELEASE THE FOLLOWING PROTECTED HEALTH INFORMATION: DATES OF SERVICE: _____**

ALL RECORDS( last 5 yrs)_____CHART NOTE_____X-RAYS_____LABS_____SUBSTANCE ABUSE INFO_____
MENTAL HEALTH_____HIV_____OTHER (PLEASE SPECIFY)_____

**SPECIFICIFY HOW THE RECORDS WILL BE UTILIZED (IF PATIENT IS REQUESTING RECORDS, STATE "*AT PATIENT'S REQUEST*"):**

**_____**

I understand that this authorization shall remain valid for one year from the date the authorization was signed.

I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying McMillan Medical Center/Ustick Medical Center in writing.

I understand I can refuse to sign this authorization and my refusal to sign said document will not affect my ability to obtain treatment, payment or my eligibility for benefits.

I understand I may inspect or copy any information used or disclosed under this agreement.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____

**SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATVIE** **DATE**

_____

**PRINTED NAME OF REPRESENTATIVE** **RELATIONSHIP TO PATIENT**



**ALL MEDICAL RECORDS REQUESTS REQUIRE 48 HOURS NOTICE TO PROCESS**