

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 REPRESENTATIVE **DATE**

PRINTED NAME OF REPRESENTATIVE **RELATIONSHIP TO PATIENT**

IMPORTANT WARNING: This information is intended for the use of the person and/or entity to which it is addressed. This information may be confidential and privileged; applicable federal and state laws govern the disclosure of which. If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this information in error please contact us IMMEDIATELY at the above number AND DESTROY THE RELATED MATERIALS.

ALL MEDICAL RECORDS REQUESTS REQUIRE 48 HOURS NOTICE TO PROCESS