PRINT

Medical Records Release Form

Authorization to Obtain or Disclose My Health Care Information

****Required**

Patient Name: _____ **Date of Birth: _____

Previous Name: _____ **Daytime Phone: _____

Date Records Needed By: _____

**Please check one:	**Please check one:
I request and authorize to: ☐ Release To ☐ Obtain From	**I request and authorize to: ☐ Release To ☐ Obtain From**
Name: ***Women's Health Associates***	Name: _____
Address: ***333 North First Street Ste 240***	Address: _____
City: ***Boise*** State: ***Idaho*** Zip: ***83702-6132***	City: _____ State: _____ Zip: _____
Phone: ***208-338-8900*** Fax: ***208-429-1350***	Phone: _____ Fax: _____

****You may use or disclose the following health care information** (check all that apply):

☐ Verbal Release (please specify what can be disclosed):

☐ Dental: ☐ Records ☐ X-rays

☐ Chart notes

☐ Lab Reports

☐ X-ray/Diagnostic Reports

☐ Medication List

☐ appointment info. only

☐ OB Records

☐ Billing Records

☐ Immunizations

☐ Other:_____

☐ All health care information does not include sensitive information, please see below(includes 2yrs, unless specified)

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.

I consent for the following information to be disclosed: (check all that apply):

_____HIV (AIDS virus) _____Sexually transmitted diseased

_____Psychiatric disorder/mental health _____Drug and/or alcohol use

**Reason for Authorization: ☐ At the request of the individual; ☐ Other: _____

**Expiration: ☐ Date: _____ OR ☐ Event (one time release):_____

MM/DD/YYYY

If date is not specified, this request will expire in 90 days from the date of signature.

If the release is for the patient's **EMPLOYER** or **FINANCIAL INSTITUTION** for reasons other than payment, this authorization will remain valid for **only 90 days**.

Patient may revoke this authorization at any time prior to expiration by notifying in writing.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted diseases, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as rquired by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. The releasor or releasee may not condition treatment, payment, enrollment or eligibility on the authorization of this release.

_____ _____ _____

****Signature/Legally Responsible Party** **Relationship to Patient** ****Date**

A minor's signature alone is sufficient to release health care information related to (1) sexually transmitted diseases, including HIV/AIDS (age 14+), (2) alcohol and/or drug abuse (age 14+) and (3) mental health information (age 14+).

_____ _____

Signature of Minor Patient **Date**