AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ City: _____State: _____

Zip: _____ PHONE: _____

THIS IS TO AUTHORIZE THAT THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION REGARDING THE ABOVE PERSON BE RELEASED

TO/ FROM: *Mikael Lagwinski, MD, FACR* *Eric Palfreyman, MD, FACR* *Svetlana Meier, MD, FACR* *Alex Feil, FNP-C* *Sara Romney, PA-C*

3277 E. Louise Dr., Ste. 350, Meridian, ID 83642
1818 S. 10th Ave., Ste. 120, Caldwell, ID 83605
Phone: (208) 887-9500 Fax: (208) 887-9800

TO/ FROM: _____

Address: _____

Phone: _____ Fax: _____

REASON FOR RELEASE: _____

☐ **Current Medical Records** ☐ **Progress Notes** ☐ **Lab Test Report** ☐ **X-Ray Reports**

☐ **Other: (please specify)** _____

Dates of Service From: _____ **To:** _____

Patient/ Guardian Signature: _____ **Date:** _____

Relationship: _____

I understand that my records may contain protected health information regarding drug or alcohol abuse, mental illness, psychiatric treatment, and/or sexually transmitted diseases, including HIV (AIDS) information. I give my specific authorization for these records to be released to be used in my care and treatment and if needed to secure payment from my insurance carrier. This authorization is valid for six months unless revoked in writing to the HIM Department before that time. Any re-disclosure of information obtained by this authorization is prohibited except with the written consent of the patient. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether the patient signed this form. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal law.