Hayden Lake
FAMILY PHYSICIANS

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient Name: _____ **Date of Birth:** _____

Address (street):_____

City: _____ **State:** _____ **Zip Code:** _____ **Phone**: _____

The following individual or organization is authorized to make the disclosure from:

_____ Hayden Lake Family Physicians _____ Other (name, address, city, state, zip, phone, fax):
_____

Release my protected health information to:

____ Hayden Lake Family Physicians _____ Other (name, address, city, state, zip, phone, fax):

_____

Include Date(s) of Treatment: _____

The Purpose for this Release is: _____

Include the following information to be disclosed: (*Please check one box for each item*)

☐ Physician Notes ☐ Lab Results ☐ X-Ray Reports ☐ MRI reports ☐ Cardiac Studies
☐ Complete Record ☐ Other (please specify): _____

PATIENT AUTHORIZATION:
I understand that that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I do not have to sign this authorization in order to obtain health care treatment.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. To revoke this authorization, I must submit my written request to the Health Information Department.

I understand that unless otherwise revoked, this authorization will expire on the following date: _____
(If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

I understand that once this information is disclosed it may no longer be protected by federal or state regulations and may be re-disclosed by the person or organization that received the information.

Signature of patient or legal representative: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____