FAMILY MEDICINE HEALTH CENTER

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTY

By signing this authorization, I authorize Family Medicine Health Center to use and/or disclose certain Protected Health Information (PHI) about me to or for the party listed below. This authorization permits Family Medicine Health Center to use or disclose to:

______________________________________ ______________________________

(Name of Individual to Whom PHI may be Released) (Relationship to Patient)

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(Phone Number)

Please describe the purpose of the disclosure:

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I authorize release of the following individually identifiable health information to the above named individual. Specifically describe the information to be released below and including such things as date(s) of service, level of detail to be released, origin of information, etc.)

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This authorization will expire on _______________________. (Expiration Date or Defined Event. If no date indicated, this authorization will expire one year from the date it was signed.)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Family Medicine Health Center has acted in reliance upon this authorization. My written revocation must be submitted to Family Medicine Residency of Idaho's Privacy Officer at 777 N. Raymond St., Boise, ID 83704. I understand that Family Medicine Health Center may not condition patient's healthcare on this authorization unless the purpose for provider's evaluation and treatment is to disclose information consistent with this authorization.

______________________________________ ___________________________

(Print name of patient whose PHI is Authorized to be released to third party (ICS)) Date of Birth or Social Security #

Signed by: ________________________________ ___________________________

Signature of Patient or Legal Guardian Relationship to Patient

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Date

FOR INTERNAL USE ONLY

Date Request Received__________________