BENEWAH COMMUNITY HOSPITAL/ST MARIES FAMILY MEDICINE
229 7th Street, St. Maries, ID 83861
Phone: 208-245-7013 Fax: 208-245-5246

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION SMFM Clinic Provider: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State & Zip: _____

Phone: _____

☐ **RELEASE MY BCH/SMFM RECORDS TO:** ☐ **REQUEST MY RECORDS FROM:** ☐ **MYSELF**

Practice Name: _____ Doctor: _____

Address: _____ City: _____ State & Zip: _____

Phone: _____ Fax: _____

RELEASE FORM/DELIVERY I would like my copies to be:

☐ Picked-up ☐ Faxed ☐ Standard Mail ☐ Certified Mail *(additional charge)*

PURPOSE FOR RELEASE

☐ Continuing Care ☐ Insurance Purposes ☐ Personal ☐ Legal Purposes ☐ Other: _____

INFORMATION TO BE RELEASED AND TREATMENT DATES

☐ 1-year Primary Care Medical History, to include ER visits, Labs, Radiology, Procedures, Test Results, and Preventative Screening Results (Mammograms, Colonoscopies, Pap Smears, DEXA Scans, Immunizations, etc.)

☐ Entire Treatment Records from Specialist for current disease/diagnosis of: _____

☐ Other: _____

I understand that the information to be released may include a diagnosis or reference to the following condition(s): mental healthcare, communicable diseases, HIV or AIDS, and/or drug and alcohol abuse.

I UNDERSTAND THAT

1. This medical information may be used by the person/facility I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
2. This authorization shall be in force and effect for 6 months, at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.
6. Federal Regulations protect you by prohibiting the release of your medical information without your specific written consent. ***Before we release protected information, this authorization must be signed by you.***

Patient or Guardian Signature: _____ **Date:** _____

Patient or Guardian Printed Name: _____ **Relationship to Patient:** _____

OFFICE USE ONLY

Request Completed by: _____ Date: _____