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

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Authorization is effective April 14, 2003, pursuant to the Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Title II, Subtitle F, §§ 261-264, Public Law 104-191.

Patient Name: _____DOB: _____Phone:_____

FROM:

1. I authorize _____ Phone: _____ Fax: _____ to disclose my health information specific to the following date or time period: _____

TO:

2. Individual or entity authorized to receive my health information: _____
3. Address:_____ Phone: _____
   _____ Fax: _____

PURPOSE:

4. For which disclosure is to be made: _____

5. Information to be disclosed:
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Operative Report
   - ☐ ER Record
   - ☐ Lab Report
   - ☐ Radiology Report
   - ☐ Pathology Report
   - ☐ Consultation
   - ☐ EKG
   - ☐ **Entire medical record (all information to the above named recipient.**
   - ☐ Billing records
   - ☐ All transcribed hospital reports.
   - ☐ Other: _____

6. I understand that this will **exclude** health information relating to (check if applicable):
   - ☐ HIV (Human Immunodeficiency Virus) infection
   - ☐ Mental Health
   - ☐ Treatment for alcohol and/or drug abuse
   - ☐ Genetic testing

7. I understand that if protected health information is disclosed to those not required to comply with the federal privacy protections, such information may be re-disclosed and would no longer be protected.

8. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. My revocation must be in writing. Unless otherwise revoked, this authorization will expire (180) days from the date of my signature.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information used/disclosed under this authorization.

Signature of Patient/Personal Representative	Date Signed	Print Name

If this authorization has signed by a personal representative on behalf of the patient, his/her authority to act on behalf of the patient must be set forth here:

_____.

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. 45 CFR Part 2 prohibits you from making any further disclosure of it without the specific and informed release of the patient to whom it pertains, their authorized representative, or as otherwise permitted by law.

Patient Label

For Office Use Only
Staff Person Releasing Information
Date Information Released