

609 Bryden Ave Suite B Lewiston, ID 83501 (208)816-8746

**AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

I authorize **Mountain View Health PLLC** to use, disclose, obtain or release my protected health information (medical records) described below which may include information concerning treatment for drug or alcohol use, psychiatric treatment, HIV/AIDS/ARC status or genetic testing to:

Provider/Entity/Person(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Family Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For the following purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of care requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Abstract (pertinent information related to your care, including all doctors notes, x-ray and lab reports) \_\_\_\_Copy of the complete medical record \_\_\_\_Surgical Report \_\_\_\_ History & Physical Report \_\_\_\_Radiology Report
\_\_\_\_ ED Report \_\_\_\_Physical Therapy Notes
\_\_\_\_ Discharge Summary \_\_\_\_Laboratory Reports. \_\_\_Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If my initials appear below, I request that you do NOT send the following records:**

\_\_\_I do not authorize release of any records concerning drug or alcohol treatment and/or psychiatric treatment. \_\_\_I do not authorize the release of any records concerning genetic testing for the purposes set forth above.

\_\_\_I do not authorize release of any records concerning my diagnosis of or treatment for HIV, AIDS or ARC, or contain some other reference to my identity as an HIV, AIDS or ARC patient for the purpose set forth above.

I understand that I may inspect or copy the protected health information described in this authorization. I understand that this authorization may be revoked in writing and delivered to Mountain View Health PLLC at any time, and that Mountain View Health PLLC must cease using this authorization, except that Mountain View Health PLLC may complete any actions it initiated in reliance on this authorization and prior to my revocation. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that Mountain View Health PLLC shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested used or disclosure and that I may refuse to sign this authorization. I understand that by authorizing this release of my medical records I also release Mountain View Health PLLC from all legal responsibility or liability that may arise from the release of these medical records.

Signature of patient or representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority of representative (parent of minor, guardian, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRATION: This authorization will expire on (date or event):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If no date or event is specified, the authorization shall expire at the end of treatment.