AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Full Name of Patient (Please Print):____

Patient's Date of Birth: ________________________________ Social Security Number: ____

Address: ____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED IS:

- o ALL HEALTH CARE INFORMATION in the medical record
- o Health care information in the medical record related to the following treatment or condition: ____
- o Health care information in the medical record for the date(s): _________________
- o Other: ____

INCLUDE the following information in the records released (please initial):

Psychotherapy Notes _____ Drug and/or alcohol use _____ Sexually related matters _____ HIV (AIDS virus) _____
Other (specify) ____

The information will be used/disclosed for the following purposes:

Transfer of Care _____ Going to Specialist _____ Insurance Purposes _____
Personal _____ Legal Purposes ____ Other (specify) ____

I request and authorize: Coeur d'Alene Pediatrics 700 W. Ironwood Drive, Suite 155 Coeur d'Alene, ID 83814	To release my records to: Clinic/Provider/Name: ____ Address: ____ City: ____________________________ State: ______________ Zip: ________________ Phone: ________________________________Fax: ______________________________

I understand that there may be a charge for this service, and I agree to pay said charge on demand.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. If Coeur d'Alene Pediatrics is asking to use/disclose my information, I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Expiration: This authorization expires on this date or event: ___________________. I understand this authorization will expire 90 days from the date signed if no specific expiration date is indicated. The authorization may be revoked by notifying Coeur d'Alene Pediatrics in writing at any time except to the extent action has been taken prior to revocation.

Signature: ____ Date: ____

Relationship to Patient: ________________________________ Phone Number: ____

Date received: ________________ Date Released: ______________ (Mail _______ In Person_______) Initials: ____________

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Coeur d'Alene, ID 83814
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Fax: (208)667-0876
PHI Fax: (208)625-2075

Post Falls
1300 E. Mullan Avenue, Suite 1000
Post Falls, ID 83854
Phone:(208)777-1330
Fax: (208)777-1329
PHI Fax: (208)625-2075

Hayden
9095 N. Hess Street
Hayden, ID 83835
Phone:(208)772-8940
Fax: (208)772-8946
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