PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____
Patient Date of Birth: _____
Patient Address: _____
Patient Phone: _____

Releasing Records From
Office/Provider Name: _____
Address: _____
Phone: _____
Fax: _____

Releasing Records To
Office/Provider Name: The Pediatric Place
Address: 1236 Bond Ave, Ste B, Rexburg, ID 83440
Phone: 208-701-0277
Fax: 208-701-0294

Dates Requested *(circle one)*: All *(since birth)* Past 1 year Past 5 years
Past 10 years Other: _____

Records to Release:

- ❏ Vaccinations
- ❏ Laboratory Reports
- ❏ Imaging Reports
- ❏ Clinical Notes
- ❏ Surgical/Pathology Reports
- ❏ **Entire Medical Record (includes all of the above)**

I, the undersigned, authorize the release of the information specified above for the above named patient. I understand that my records are confidential and cannot be disclosed without my written authorization, except when permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV/AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient