AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Meridian Family Medicine
1525 E Leighfield Dr, #150
Meridian, ID 83646
Phone: 208-888-1199 Fax: 208-888-0807

The above healthcare facility is hereby authorized to release medical information on

Patient Name: _____ **DOB:** _____

Medical Information Requested:

- ☐ All Medical Records
- ☐ Allergies
- ☐ Discharge Summaries
- ☐ History and Physicals
- ☐ X-Ray Films
- ☐ Laboratory Data
- ☐ Medications
- ☐ Operative Findings
- ☐ X-Ray Reports
- ☐ Other: _____

Reason for Releasing Records:

☐ Transfer of Care ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: _____

Release Records To:

Name of Person(s)/Facility: _____ Phone/Fax: _____

Mailing Address: _____

In accordance with HIPAA laws, this release is in effect for one year after today, or when patient revokes.

Medical records are confidential and re-disclosure is prohibited.

CONSENT: I hereby consent to the release of medical information as stated above.

Signature of Patient: _____ **Date:** _____

IF SIGNING FOR A MINOR:

Signature of Parent/Legal Guardian/Authorized Agent: _____ Date: _____

Printed Name: _____

Relationship: _____