Authorization to Release Medical Information

Meridian Family Medicine

Phone: 208-888-1199 / Fax: 208-888-0807

(Health Care Provider)

Is herby authorized to release medical information on

____

(Patient Name)

Date of Birth: _______________

Medical information requested:

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

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

Information requested by: ______________________________ Relationship to Patient: ________________

Records should be sent to: _____________________________ Phone/Fax: __________________________

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

______________________________________ Signature of Patient

______________________________ Date

______________________________________ Signature of Authorized Agent

______________________________ Relationship of Agent

Medical records are confidential and re-disclosure is prohibited.