David Butuk, MD
Scott Frisby, PA-C
Jennifer Ritchie, PA-C

Meridian
FAMILY MEDICINE

Meredith Mangum, FNP-C
Shauna Lacow, FNP-C
Janelle Barney, FNP-C

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

CURRENT ADDRESS: _____ PHONE: _____

I authorize disclosure of the above-named individual's protected health information as described below.

I HEREBY AUTHORIZE MERIDIDAN FAMILY MEDICINE TO REQUEST MEDICAL INFORMATION FROM:
(PREVIOUS PHYSICIAN)

PHYSICIAN/FACILITY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ FAX NUMBER: _____

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED:

☐ COMPLETE MEDICAL RECORD *(All healthcare information including immunization records, well visit exams, progress notes, labs, x-rays, growth charts, medications, allergies, specialist notes, hospital notes, etc.)*

☐ OTHER *(please specify):* _____

REASON FOR REQUEST: ☐ Continued Treatment ☐ Transfer of Care ☐ Other: _____

I AUTHORIZE THE ABOVE INFORMATION TO BE RELEASED TO:
MERIDIAN FAMILY MEDICINE
1525 E LEIGHFIELD DR, #150
MERIDIAN, ID 83646
PHONE: (208)888-1199 FAX: (208)888-0807

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.

_____ _____
Signature of Patient *(required for age 18 and over)* **Date**

_____ _____
Signature of Parent/Guardian/Authorized Agent *(required for under age 18)* **Relationship to Patient**