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

Authorization for Release of Medical Information

Patient Information

Patient Name:	Date of Birth:	Phone:	
Address:	City:	State:	Zip:

Authorization for Release

I hereby authorize Meridian Family Medicine

☐ **TO RELEASE MY INFORMATION TO** ☐ **TO OBTAIN MY INFORMATION FROM**

Name of Person/Facility/Entity: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone Number: _____ Fax Number: _____

Preferred Method of Release: ☐ Mail ☐ Fax ☐ Pick Up

Description/Purpose of Disclosure

Information to Release:	**Dates of Service:**	**Purpose of Disclosure:**
☐ **Complete Medical Record**	☐ All	☐ Transfer of Care
☐ Immunizations	☐ From _____ To _____	☐ Continuity of Care
☐ Labs/Pathology		☐ Legal
☐ Imaging Reports		☐ Personal
☐ Billing		☐ Other: _____
☐ Other: _____		

Consent for Disclosure

The disclosure of records as part of this authorization may contain sensitive information protected by federal law pertaining to the history, diagnosis, or treatment of drug/alcohol abuse, mental health, HIV/AIDS status, sexually transmitted diseases, and genetic testing unless otherwise restricted.
Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law.
I understand that I have the right to receive a copy of this authorization.
Refusal to sign this authorization will not affect consent to the use or disclosure of protected health information for purposes of treatment, payment, or health care operations.
This authorization may be revoked at any time by providing a written request to Meridian Family Medicine. If you revoke this authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire 1 year from the date signed below or will expire on the following date, event, or condition: _____.

X_____ _____/_____/_____
Signature of Patient/Parent/Legal Representative Date

_____ _____
Printed Name Relationship to Patient