25 Jacobs Gulch, Kellogg, Idaho, 83837 * 208-784-1221
Medical Records Fax: 208-784-0961

Authorization for Use and Disclosure of Health Information

Version No.: 1

I authorize ______________________________ to disclose the following information from the record of:

PATIENT INFORMATION		
Patient Name		**Date of Birth**
Address		**Phone Number**
City	**State**	**Zip Code**

REQUESTED INFORMATION				
DATES OF SERVICE	**From:**			**To:**
	All Records		**Laboratory Results**	**Other (Specify)**
	Radiology Reports		**Radiology Films**	

PURPOSE FOR REQUEST					
	Self		**Medical Care**		**Attorney Request**
Other (Specify)					

INFORMATION TO BE GIVEN		
Company, Person, Facility		**Phone Number**
Address		
City	**State**	**Zip Code**

THIS AUTHORIZATION IS VALID UNTIL: ______________________________

(If an expiration date, event or condition is not specified, this authorization will expire ***90 days*** *from the date signed.)*

I understand that Shoshone Medical Center will not condition my treatment on whether I sign this authorization unless it is for research-related treatment, or my treatment is solely for the purpose of disclosing information to a third party (i.e. and employment physical.

I understand that once the authorized person or organization receives this information it may be subject to re-disclosure and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this authorization, in writing, to Shoshone Medical Center, at any time. I understand that the revocation will not apply to information that has already be released in response to this authorization.

______________________________ ______________

Signature of Patient **Date**

______________________________ ______________ ______________

Signature of Legal Representative **Date** **Relationship to Patient**

______________________________ ______________

Signature of Witness **Date**

FOR SHOSHONE MEDICAL CENTER USE ONLY		
RELEASED BY	**PROCESSED BY / DATE**	**DATE MAILED:**
		DATE FAXED:
		DATE PICKED UP:

PROVIDE A SIGNED COPY OF THE AUTHORIZATION TO PATIENT.