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

Privacy: Authorization for Use and Disclosure of Health Information

Version No.: 2

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**

PATIENT AUTHORIZATION			
I understand that my records may contain information regarding the diagnosis or treatment of HIV / AIDS, sexually transmitted diseases, drug and / or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released with the exception of the following selected documents:			
☐	**Drug / Alcohol abuse / treatment & diagnosis**	☐	**Sexually Transmitted Disease**
☐	**HIV / AIDS diagnosis / treatment / testing**	☐	**Genetic Records**
☐	**Mental Illness or Psychiatric diagnosis / treatment**		

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.