425 W. Bannock St. • Boise, Idaho 83702
2235 E. Gala St. • Meridian, Idaho 83642
1200 Garrity Blvd.• Nampa, Idaho 83687

IDAHO GASTROENTEROLOGY ASSOCIATES, LLP

Phone: 208.343.6458
Fax: 208.343.5031
Web: IdahoGastro.com

AUTHORIZATION TO ACCESS, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____Other names under which_____
patient has been treated.

DATE OF BIRTH: _____CURRENT PHONE#: Cell# _____Home#_____

RECORDS RELEASED FROM: _____
Physician/Medical Office

_____
Address

_____
City **State** **Zip** **Phone/Fax**

TO: _____
Name

_____
Address

_____
City **State** **Zip** **Phone/ Fax**

I hereby authorize and request the release of the following information:

_____Patient information for visit date(s) from_____ to_____
_____Specific records –_____

Purpose for release of information:
_____

CHOOSE ONE FORMAT FOR RECEIVING THE INFORMATION: Paper mail _____Electronic Copy _____
Fax _____ Other _____

As the patient, you are agreeing that all medical records will be released unless you have specifically requested that the following sensitive information not be released. Please circle the information you wish to be withheld:
HIV status
Mental Health,
Drugs and Alcohol

SIGNATURE: _____DATE_____

If not signed by the patient, please indicate relationship: Print name: _____
[ ] parent or guardian of minor patient (to the extent minor could not have consented to the care)
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient
[ ] spouse or person financially responsible (where information solely for purpose of processing application for defendant health care coverage)

I may revoke this authorization in writing at any time by writing to Idaho Gastroenterology at 425 West Bannock Street, Boise, Idaho 83702 attention medical records. I understand that the revocation will not apply to information that has already been released. I understand that this authorization for release of information is voluntary. I can refuse to sign this authorization and know that I do not need to sign to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimiles of this authorization shall be the same as a signed original document.

This authorization expires on: _____ (OTHERWISE WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED