



AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Release To: TREASURE VALLEY PEDIATRICS

1620 S. Celebration Ave  
Meridian, Idaho 83642  
Fax: 208.884.3058

305 E. Jefferson, Suite 101  
Boise, Idaho 83712  
Fax: 208.345.1142

450 W. State St. Suite 100  
Eagle, Idaho 83616  
Fax: 208-939-8970

Release From: \_\_\_\_\_ (Physician/Institution that presently has data)

\_\_\_\_\_  
Street Address City State Zip  
\_\_\_\_\_  
Phone Fax

I. **My Authorization**

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above-named practice  
(Circle "include" or "exclude" for each of the following)  
Include or Exclude My health information related to drug abuse  
Include or Exclude My health information related to alcohol abuse  
Include or Exclude My health information related to HIV/AIDS  
Include or Exclude My health information related to psychological or psychiatric conditions
- Other: \_\_\_\_\_

Reason(s) for this authorization (check all that apply):

- At my request
- Other \_\_\_\_\_

This authorization ends: \_\_\_\_\_ (date) or until \_\_\_\_\_ (List specific event)

If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

II. **My Rights**

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing by sending a letter to the office. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization.

\_\_\_\_\_  
Patient or legally authorized individual signature Date Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative.)