



AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient name: _____ Date of birth: _____

Release From: TREASURE VALLEY PEDIATRICS

1620 S. Celebration Ave
Meridian, Idaho 83642

305 E. Jefferson, Suite 101
Boise, Idaho 83712

450 W. State St. Suite 100
Eagle, Idaho 83616

Release To: _____

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.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative.)