Southeastern Idaho Public Health

Authorization for Release of Information

Patient Label

_____ _____ ___ _____/_____/_____
Last Name First Name MI Birth Date

_____ _____ _____ _____
Address City State Zip

(_____)_____ _____
Telephone Number Alternate Contact Information

I hereby authorize Southeastern Idaho Public Health to:

❑ ***Obtain Information FROM:*** ❑ ***Release Information TO:***

_____ (_____)_____ (_____)_____
Health Care Provider/Facility Fax Number Telephone Number

_____ (_____)_____ (_____)_____
Health Care Provider/Facility Fax Number Telephone Number

Specific Information Requested:

❑ History & Physical, most recent ❑ Pap Smear report, most recent ❑ Last 3 Pap Smear reports ❑ Colposcopy Info & F/U Plan

❑ Contraceptive Info (□ *Name of Birth Control Pill* □ *Date of Last Depo Injection* □ *IUD Insertion Notes*) ❑ Immunization Records

❑ Lab Reports _____ ❑ OTHER _____

Please fax or mail this information to:

Southeastern Idaho Public Health
1901 Alvin Ricken Drive
Pocatello, Idaho 83201
Phone (208) 233-9080
Fax (208) 478-9297

Purpose of this Request: ❑ Continuing Care / Treatment ❑ Billing /Insurance ❑ Other_____

I understand that my medical record may contain personal or sensitive information. Release of this information is voluntary and protected by law. This facility, its employees, officers, and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I specifically authorize the disclosure and release of the following information to the persons/clinic indicated above in accordance with IDAPA 16.05.01 Protection and Disclosure of Department Records, Public Health Act Section 523-527. Disclosure of this information by any entity subject to HIPAA privacy regulations to a person/entity may be subject to re-disclosure by the recipient without my further authorization.

❑ Yes ❑ No Specifically consent to authorize release of HIV/AIDS diagnosis/treatment/testing.
❑ Yes ❑ No Specifically consent to authorize release of sexually transmitted disease(s) diagnosis/treatment.
❑ Yes ❑ No Specifically consent to authorize release of drug or alcohol abuse diagnosis/treatment.
❑ Yes ❑ No Specifically consent to authorize release of mental or psychiatric illness diagnosis/treatment.

Requests must be made in writing by using this Authorization for Release of Information form. Unless revoked, this authorization will expire 24 months from the date signed.

_____ _____
Client or Representative Signature (legal relationship to client if applicable) Date

_____ _____
Staff Witness Signature Date

Date Sent_____ Sent by_____ Date Received_____ Received by_____