Idaho Falls Pediatrics
3067 Eagle Drive, Ammon, ID 83406
1645 Pancheri Dr., Idaho Falls, ID 83402
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(208) 522-4600 • Fax: (208) 552-7521

Medical Record Release

Authorization to release medical information and/or medical records

Patient Name: _____ Date of Birth _____

I authorize Idaho Falls Pediatrics to use or disclose Protected Health Information (PHI) contained in my Medical Records in the following manner:

To:

Person/Institution requesting data **Fax #**

_____

_____

Street Address **City** **State** **Zip** **Phone**

From: Idaho Falls Pediatrics, 3067 Eagle Drive, Ammon, ID 83406 (208) 522-4600

_____

Doctor's name **City** **State** **Zip** **Phone**

Please Release the following Protected Health Information:

____ All Records ____ Chart Notes ____ X-Rays ____ Labs ____ Mental Health
____ Other (please specify):
_____

The Protected Health Information is being used or disclosed for the following purpose(s): (If the patient is requesting the release, this may state "at patient's request')

_____
_____
_____

(List specific purposes the Protected Health Information will be utilized)

Expiration date of release

This authorization is effective through ___/___/___ unless revoked or terminated by the patients parents or guardian.

I understand that I have the right to revoke this authorization in writing by sending notification to the address above

I understand that when I revoke this authorization, it is not effective to the extent that the clinic has already relied on the use or disclosure of the Protected Health Information.

I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law.

The clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is soley for the purpose of creating Protected Health Information for disclosure to a third-party.

I understand that I have a right to inspect or copy the Protected Health Information to be used or disclosed.

I understand that I have a right to refuse to sign this authorization.

If you have any questions concerning this form, please contact the clinic manger.

Signature of Parent/Guardian_____Date_____