Idaho Falls Pediatrics

Ron W. Porter M.D. Scott A. Smith D.O. Joseph R. Moore M.D.
Mitchael C. Steorts M.D. J.Tyrell Webb D.O.
Travis A. Christensen PA-C ,Jackie Romrell FNP-C ,
Kamlyn Harker PA-C, Morgan Tingle PNP

Medical Record Release

Authorization to Release Medical Information and/or Medical Records

Patient Name: _____Date of Birth _____
Address: _____
Street Address City State Zip
Phone Number: _____
I authorize Idaho Falls Pediatrics to use or disclose Protected Health Information (PHI) contained in my Medical Records in the following manner:

From: Idaho Falls Pediatrics, 3067 Eagle Dr. Ammon, ID 83406
Phone # (208) 522-4600 Fax # (208) 552-7521
Email (preferred) medicalrecords@secure.ifpeds.com

To: _____
_____
Street Address City State Zip

Email (preferred)_____
Phone_____ Fax_____

Please release the following Protected Health Information:
____ All Records ____Health & Physical ____Immunizations ____ Labs
___Other (please specify) _____

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 had already relied on the use of 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 solely 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 manager.

Name of Parent/Guardian requesting record _____

Signature of Parent/Guardian _____Date_____