IRONWOOD
Family Practice

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Full Name of Patient (Please Print) :_____

Maiden Name/Alias: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED IS:

☐**ALL HEALTH CARE INFORMATION** in the medical record

☐Health care information in the medical record related to the following treatment or condition:

_____

☐Health care information in the medical record for the date (s): _____

☐Other (e.g. x-rays, bills), specify date (s): _____

INCLUDE the following information from the records released (please initial):

Mental Health Notes/Psychotherapy Notes_____ Drug and/or alcohol use_____ Sexually transmitted diseases_____

HIV (AIDS virus)_____ Other _____

This record is requested for the following reason:

☐Transfer of Care to (Name of Provider):_____

☐Going to Specialist ☐Insurance Purposes ☐Personal Interest ☐Legal Purposes

☐Other (specify)_____

**** FOR MULTIPLE PROVIDERS/CLINICS, PLEASE LIST ON BACK OF THIS FORM.**

I request and authorize:	**To release my records to:**
Clinic/Provider: _____	Ironwood Family Practice
Address: _____	920 Ironwood Drive, Suite 101
City: _____ State: _____ Zip: _____	Coeur d'Alene, ID 83814
Phone: _____ Fax: _____	Phone (208) 667-4557 Fax (208) 765-2887

I understand that there may be a charge for this service, and I agree to pay said charge on demand.

I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. If Ironwood Family Practice is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

SIGNATURE: _____ **DATE:** _____
Patient, Parent, or Legally Authorized Individual

Relationship to the Patient:_____

Social Security Number: _____ Phone Number: _____

Expiration: This authorization expires on this date or event: _____. **I understand this authorization will expire 90 days from the date signed if no specific expiration date is indicated.** The authorization may be revoked by notifying Ironwood Family Practice in writing at any time except to the extent action has been taken prior to revocation.

I request and authorize:
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Address: ____
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