# EASTERN IDAHO REGIONAL MEDICAL CENTER

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**This section must be completed for all Authorizations**

| **Patient Name:** | **Birth Date:** | **Social Security No. *(optional)*:** | |
|---|---|---|---|
| **Provider's Name:**<br>Eastern Idaho Regional Medical Center | **Requester or Authorized Recipient's Name:** | | |
| **Provider's Address:** | **Phone Number:** | | |
| 3100 Channing Way<br>Idaho Falls, ID 83403-2077 | **Address:** | | |
| | **City:** | **State:** | **Zip:** |

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
**Date:** **30 days / 60 days / 90 days** (Please circle one) or **Event:**

**Purpose of disclosure:**

## Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

| Description: | | Description: | | Description: | |
|---|---|---|---|---|---|
| ❑ Complete medical record | | ❑ Laboratory reports | | ❑ Other: | |
| ❑ Admission form | | ❑ Radiology reports | | ❑ Other: | |
| ❑ Discharge summary | | ❑ Cardiology reports | | ❑ Other: | |
| ❑ History & Physical Report | | ❑ EKGs | | ❑ Therapy (PT,OT,ST) | |
| ❑ Consultation report | | ❑ Physician Orders | | ❑ Nurses notes | |
| ❑ Operative report | | ❑ Physician Progress notes | | ❑ Labor/delivery summary | |
| ❑ Procedure report | | ❑ Medication sheets | | ❑ OB documentation | |
| ❑ Emergency room report | | ❑ Anesthesia report | | ❑ UB-92 | |
| ❑ Consents | | ❑ Transfer forms | | ❑ Itemized bill | |

Date(s) of Service requested:

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ________________ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.

## Signatures / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / /

I have read the above and authorize the disclosure of the protected health information as stated.

| **Signature of Patient/Guardian/Patient Representative:** | **Date:** |
|---|---|
| **Print Name of Patient's Representative:** | **Relationship to Patient:** |

Released by: ______________________________ Date: ________________________I.D. verified: ____