Southeastern Idaho Public Health

Authorization for Release of Information

_____ _____/_____/_____

Last Name **First Name** **MI** **Birth Date**

_____

Address **City** **State** **Zip Code**

Phone Number (_____) _____-_____ **Other Possible Name/s on Records**_____

I hereby authorize Southeastern Idaho Public Health to Release Information to:

_____ (_____)_____ (_____)_____

Health Care Provider/Facility **Fax Number** **Telephone Number**

❑ Immunization Records ❑ History & Physical, most recent ❑ Pap Report, most recent

❑ Last 3 Pap Reports ❑ Name of Birth Control Method ❑ Date of Last Depo Injection

❑ IUD Insertion Notes ❑ Other _____

Please deliver to any SIPH county office, FAX, or MAIL this information to:

Southeastern Idaho Public Health 1901 Alvin Ricken Drive Pocatello, Idaho 83201

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 and will expire in 24 months from date signed unless revoked. For questions or assistance, call 208.233.9080, clinic services.

_____ _____/_____/_____

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