Saint Alphonsus

1055 N. Curtis Rd. • Boise, ID 83706 • (208) 367-2121

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name (Including maiden name)

Have you been here under any other name(s)?

Birth date	Medical Record Number

I authorize the use or release/disclosure of protected health information regarding the named individual as described below.

The following person or organization is authorized to DISCLOSE the specified information:

Name: SAINT ALPHONSUS REGIONAL MEDICAL CENTER

Street Address: HEALTH INFORMATION MANAGEMENT 1055 N. Curtis Road

City, State, Zip: Boise, Idaho 83706

Phone Number:

The following person or organization is authorized to RECEIVE the information:

Name:

Street Address:

City, State, Zip:

Phone Number:

This information is to be used for the following purpose(s) only:

The specific information to be released/disclosed is specified below: ☐ Complete Medical Record

☐ Inpatient/Outpt Surgery
Date(s): ____________
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Orders
- ☐ Laboratory
- ☐ X-rays,
- ☐ Pertinent Record Set
- ☐ ____________
- ☐ ____________

☐ Emergency Dept.
Date(s): ____________
- ☐ ER Report
- ☐ Complete Record
- ☐ ____________
- ☐ ____________

☐ Billing Records
- ☐ Claim Form
- ☐ Detailed Bill

☐ Other Outpatient Dept.
- ☐ ____________
- ☐ ____________
- ☐ ____________

☐ Outpatient Diag. Tests

Test	Date
☐ Laboratory	____
☐ X-rays	____
☐ CT Scans	____
☐ Nuclear Med	____
☐ EEG	____
☐ EKG	____
☐ Vascular Study	____
☐ Sleep Study	____
☐ Echocardiogram	____
☐ Pulmonary Test	____
☐ Other	____

☐ Cancer Treatment Ctr.
Date(s): ____________
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Treatment Summary
- ☐ Laboratory Reports
- ☐ Follow-up Reports
- ☐ Consultations
- ☐ Progress Notes
- ☐ X-rays/CT/Nuclear Med
- ☐ EKG
- ☐ ____________
- ☐ ____________

I understand that the information described above may be re-disclosed in which case it is no longer protected by patient privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operation's, nor is my treatment or payment for treatment conditional on my signing this authorization.

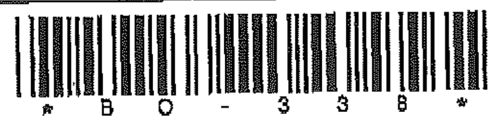
I understand that I may revoke this authorization in writing at any time at the address found below, except to the extent that information has already been released and/or used in response to this authorization, or an authorization, otherwise received by Saint Alphonsus. Unless otherwise revoked, this authorization will expire on the following date or event: __________ If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it. ______Initials

Signature of Patient or Legal Representative: ______________________ **Date:** ____________

Name of Personal Representative (if applicable) (Please print): ______________________ **Relationship to Patient:** ____________



(A copy of this signed form will be provided to the patient or legal representative.) Address: Saint Alphonsus Regional Medical Center, Health Information Management, 1055 N. Curtis Road, Boise, ID 83706, Phone: 208-367-2101