PRIMARY HEALTH MEDICAL GROUP
AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ **FORMER NAME(S)** _____

DOB_____ **CURRENT PHONE#**: _____

I HEREBY AUTHORIZE **PRIMARY HEALTH MEDICAL GROUP** **OR** From: _____
MEDICAL RECORDS DEPARTMENT _____
10482 W. CARLTON BAY DRIVE _____
GARDEN CITY, ID 83714 208-955-6501 (FAX)

TO RELEASE MY MEDICAL RECORDS TO: NAME: _____

ADDRESS: _____

PHONE#: _____ FAX#: _____

NAME: _____

ADDRESS: _____

PHONE#: _____ FAX#: _____

RECORDS TO BE RELEASED:

☐ **PRIOR TWO YEARS** ☐ **PAST YEAR** ☐ **OTHER**_____

(Copying fee may apply - see below)

I PREFER TO HAVE THESE RECORDS: ☐ **FAXED** ☐ **MAILED** ☐ **PICKED UP @** _____
OR (**CLINIC NAME OR ADMINISTRATION OFFICE**)

☐ **E-MAILED – PLEASE PROVIDE E-MAIL ADDRESS:** _____

(REQUIRES LOG IN TO ENCRYPTED WEBSITE)

WE PROVIDE THE PAST TWO YEARS OF ELECTRONIC RECORDS FREE OF CHARGE IF GOING TO THE PATIENT OR ANOTHER PHYSICIAN. The patient will be charged copying fees for any additional records as follows: up to 50 pages $15, 51-100 pages $25, and anything over 100 pages $50. All charges must be pre-paid.

_____ **If you do not wish to release records containing information regarding the diagnosis or treatment of HIV (aids virus), other sexually transmitted diseases , drug and or alcohol abuse, mental illness or psychiatric treatment, please initial here or it will be deemed permissible to release.** Upon request, I may limit the amount of time that this consent for release of information is valid; I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization and know that I do not need to sign to assure treatment. I understand that any disclosure of information carries with it the potential of unauthorized re-disclosure by the recipient. Photocopies or facsimile of this authorization shall be considered to be the same as a signed original document. This authorization confirms to the regulations promulgated under Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1987 and of Section 408 of the Drug Abuse Office and Treatment Act of 1972.

SIGNATURE: _____ **DATE:** _____
Relationship to patient (if parent or guardian): _____

WE WILL NOT SEND RECORDS TO A THIRD PARTY UNLESS THE REQUEST COMES FROM THAT THIRD PARTY WITH THE PROPER AUTHORIZATION ON THEIR LETTERHEAD.

This version to be used after 4/3/12