Authorization for Disclosure of Protected Health Information

Date Information Desired by:	Patient Name: _____ Date of Birth _____ Address (including City/State/Zip): _____ Phone Number: _____ Maiden/Previous Names/Nicknames: _____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Release Information From:

Provider/Facility Name: _____

Address: _____

City/State/Zip _____

Phone: _____

Release Information To:

Name/Facility: Olscamp Orthopedics

Address: 1551 E. Mullan Ave, Suite 100

City/State/Zip Post Falls, ID 83854

Phone: 208-457-4211

For continuing care, fax #: 208-773-1473

Purpose of Release:

- ☐ Continuing Medical Care
- ☐ Insurance Claim
- ☐ Application for Insurance
- ☐ Work Comp
- ☐ Disability Determination
- ☐ Personal
- ☐ Other: _____

Information to be Released:

Release Format: ☐ Paper ☐ CD/DVD **Release Method:** ☐ Mail ☐ Pick Up ☐ Fax *(continuing care only)*

Service Dates: From: _____ To: _____

- ☐ Clinic Progress Notes
- ☐ Hosp Progress Notes
- ☐ History & Physical
- ☐ Consultation Notes
- ☐ ER Records
- ☐ Discharge Summary
- ☐ EKG/Cardiology Reports
- ☐ Pathology Reports
- ☐ Operative Reports
- ☐ Other: _____
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Substance Abuse Evals/Assmt
- ☐ Psychological Evals/Assmts
- ☐ Immunization Records
- ☐ All Records
- ☐ Billing Statements

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section titled "Release Information To." I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

ATTENTION: Please review the information below carefully. If information is missing the request may not be processed.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and lacks capacity to sign,** a legally authorized person may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature *(required)*:	Date Signed *(required)*:
Printed Name of Person Signing (If not patient):	

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