Authorization for Disclosure of Protected Health Information

Date Information	Patient Name:Date of Birth							
Date information Desired by:	Address (including City/State/Zip):							
•	Phone Number:							
	Maiden/Previous Names/Nicknames:							
	I Waldelin	in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.						
			Release Informati	ion To:				
Release Information From:			Name/Cocility	Name (Coolling				
Provider/Facility Name:			Olscamp Urthopedics					
Address:			Address: 1551 E. Mullo	Address: 1551 E. Mullan Ave, Suite 100				
City/State/Zip				Post Falls, 10 83854				
Phone:			Phone: 208-45	Phone: 208-457-4211				
				For continuing care, fax #: 208-773-1473				
Purpose of Releas	e:							
☐ Continuing Medical Care ☐ Work Comp ☐ Other:								
☐ Insurance Claim								
Application for Ins	surance	☐ Personal _						
Information to be I	Release	d:						
Release Format: Paper CD/DVD Release Method: Mail Pick Up Fax (continuing care only)								
Service Dates:	From:		•					
Clinic Progress No		Discharge Summary	☐ Lab Reports	☐ Psychological Evals/Assmts☐ Immunization Records				
Hosp Progress No		☐ EKG/Cardiology Reports ☐ Pathology Reports	☐ Radiology Reports ☐ Radiology Images	☐ All Records				
☐ History & Physica☐ Consultation Note		Operative Reports	☐ Substance Abuse Ev					
☐ ER Records		Other:						
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 wi	ill expire	one year from the date of signir	ng unless I indicate an ev	ent or earlier date here:				
• If the patient is • If the patient is • If the patient is • Please indicate y □ Legal (e review the review th	he information below carefully. If of age or older, the patient mus of age or older and facks capa authority and include documents or Conservator.	information is missing the st sign and date the form. acity to sign, a legally aut ation of your relationship: h Care Agent (Health Care sparent or legal guardian research).	horized person may sign and date the form. Power of Attorney) must sign and date the form, unless an				
Signature (required):				Date Signed (required):				
Printed Name of Person	on Signing	g (If not patient):						

Authorization for Disclosure of Protected Health Information

Date Information	Patient Name: Date of Birth							
Desired by:	Address (including City/State/Zip):							
	Phone Number:							
	Maiden/Previous Names/Nicknames:							
Instructions: Fill out for	1	entirety. If any section is incompl						
Release Information			Release Inf	formation To:	,			
				Name/Facility:				
Olscamp Orthopedics				Address				
Address: 1551 E. Mullan Ave, Suite 100			Address:					
City/State/Zip Post Falls, ID 83854			City/State/Zip	City/State/Zip				
Phone: 208-457-4211			Phone:	Phone:				
208 (31	\		For continuin	g care, fax #:				
Purpose of Releas	se:							
☐ Continuing Medical Care ☐ Work Comp ☐ Other:								
☐ Insurance Claim								
Application for Ins	surance	☐ Personal						
Information to be I	Release	d:						
Release Format: Paper CD/DVD Release Method: Mail Pick Up Fax (continuing care only)								
Service Dates:	From:		_					
Clinic Progress No	otes	Discharge Summary	☐ Lab Reports ☐ Radiology Re	norto	☐ Psychological Evals/Assmts☐ Immunization Records			
☐ Hosp Progress No☐ History & Physica		☐ EKG/Cardiology Reports ☐ Pathology Reports	Radiology Ima		☐ All Records			
☐ Consultation Note		Operative Reports	☐ Substance Ab	ouse Evals/Assmt	☐ Billing Statements			
☐ ER Records		Other:						
noted above. However this authorization is contest a claim under the hereby authorize the party identified in the	ver, the robtained er the pole above escription	olicy or the policy itself. It facility/provider to disclose many ittled "Release Information T	ion was previously nsurance coverag nedical information o." I understand th	taken in reliance e; other law prov a concerning the nat the informatio	above named patient to the not 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.								
WIII not anect my ab This authorization wi	III expire	one year from the date of signi	ng unless I indicate	e an event or earl	ier date here:			
		ne information below carefully. If						
 If the patient is an appearance of the patient is a please indicate your Legal Control of the patient is a patient in a patient is a patient in a patient is a patient in a patien	18 years 18 years our legal Guardian 17 years	of age or older, the patient mus of age or older and lacks capa authority and include document	st sign and date the acity to sign, a lega ation of your relation he Care Agent (Heal sparent or legal guars)	form. ally authorized per nship: th Care Power of <i>i</i> ardian must sign a	rson may sign and date the form. Attorney)			
Signature (required):					ned (required):			
Printed Name of Person Signing (If not patient):								