IRONWOOD
Family Practice

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Full Name of Patient (Please Print) :_____

Maiden Name/Alias: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED IS:

☐**ALL HEALTH CARE INFORMATION** in the medical record

☐Health care information in the medical record related to the following treatment or condition:

_____

☐Health care information in the medical record for the date (s): _____

☐Other (e.g. x-rays, bills), specify date (s): _____

INCLUDE the following information from the records released (please initial):

Mental Health/Psychotherapy Notes _____ Drug and/or alcohol use_____ Sexually transmitted diseases_____

HIV (AIDS virus)_____ Other _____

This record is requested for the following reason:

☐Transfer of Care ☐Going to Specialist ☐Insurance Purposes

☐Personal Interest ☐Legal Purposes ☐Other (specify) _____

I request and authorize:	**To release my records to:**
Ironwood Family Practice	Clinic/Provider/Patient Name: _____
920 Ironwood Drive, Suite 101	Address: _____
Coeur d'Alene, ID 83814	City: _____ State: _____ Zip: _____
Phone (208) 667-4557 Fax (208) 765-2887	Phone: _____ Fax: _____

I understand that there may be a charge for this service, and I agree to pay said charge on demand.

I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or bloodborne infectious disease, which are subject to federal and/or state restrictions on disclosure. If Ironwood Family Practice is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

SIGNATURE: _____ **DATE:** _____
Patient, Parent, or Legally Authorized Individual

Relationship to the Patient:_____

Social Security Number: _____ Phone Number: _____

Expiration: This authorization expires on this date or event: _____. **I understand this authorization will expire 90 days from the date signed if no specific expiration date is indicated.** The authorization may be revoked by notifying Ironwood Family Practice in writing at any time except to the extent action has been taken prior to revocation.