LOST RIVERS Medical Center

Office Use Only MR#_____

❑ Mailed ❑ Fax ❑ In person ❑ Workers Comp

❑ ID checked /Initials

AUTHORIZATION TO ACCESS, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient: _____ Date of birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone number(s): Cell # _____Home #_____ Work #_____

Other names under which patient has been treated: _____

Release Information From: The following entity/individual is authorized to disclose my PHI:	**Release Information To:** The following entity/individual is authorized to access, use, and receive my PHI:
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____ Fax: _____	Phone:_____ Fax: _____
☐Lost Rivers Medical Center, 551 Highland Dr. Arco, ID 83255	☐Lost Rivers Medical Center, 551 Highland Dr. Arco, ID 83255

Purpose of Use and Disclosure:

☐Insurance ☐Legal ☐Personal ☐Treatment/Continued Care ☐Workers Compensation ☐School
☐Employee Wellness ☐Occupational Services ☐Other _____

This request is valid for services for the following dates (select one of the following options):

☐ Approximate service date(s)_____
☐ All visits between the dates_____ and_____
☐ All visits between the date_____ and the expiration date of this form.

Information to be Used or Disclosed:

☐Billing Information	☐Immunizations and/or Titers	☐Health Assessment
☐Discharge Summary	☐Lab/Pathology	☐Operative/Procedure Report
☐Emergency Room Record	☐Medication List	☐Substance Use Disorder
☐History/Physical	☐Employment/DOT Physical	☐Drug and/or Alcohol Results
☐Clinic/Progress Notes	☐Physical Therapy Notes	☐Mental Health Evaluation/Studies
☐Medical Clearance	☐Problem List	☐Imaging Report(s) Typed ONLY
☐Health Assessment	☐Other: (Specify)_____	☐Imaging Disc w/report (CT, MRI, XRAY)
☐Consultation Reports		

Choose one format for receiving the information: ☐Paper ☐Fax ☐Electronic copy ☐ Email _____☐Other_____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and genetic testing. **Please note that psychotherapy notes require a separate authorization**.

I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. **To revoke this authorization, I must submit a written revocation to Health Information Management (Medical Records) at Lost Rivers Medical Center.**

I understand that my health care cannot be conditioned on this authorization unless the purpose is solely to obtain and disclose information for a third party, such as an employer.

I understand that information disclosed by Lost Rivers Medical Center pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

_____ _____ _____
Signature **Date** **Time**

_____
Relationship to the Patient (If applicable)

THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED

☐ The patient has previously signed an ROI authorization granting me access to their PHI or I have legal paperwork granting access. (attach)

THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED