Authorization for Use and Disclosure of Protected Health Information MR#:_______________________

Lost Rivers District Hospital
551 Highland Drive
Arco, Idaho 83213
Ph. (208)527-8206
Fax (208)527-3105

PATIENT IDENTIFICATION:

Name: ___________________________ Birth Date:_________________
Address: ____
____
Social Security #:______________________Telephone:______________

PERSON AUTHORIZED TO RECEIVE INFORMATION

Name: ____

Address: ____

____

Telephone :(_____) _____________Fax: (_____) _____________

DATES OF INFORMATION TO BE RELEASED

From (date):_______________To (date):_________________

From (date):_______________To (date):_________________

PURPOSE OF REQUEST:

_____ Treatment of consultation _____At the request of the patient ______ Billing or claims payment

Other: ____

TYPE OF INFORMATION TO BE RELEASED

______Emergency room report ______Laboratory test reports ______X-ray reports

______Operative report ______History and Physical Exam ______X-ray films / Images

______Discharge summary ______Consultation reports ______Itemized bill

Other: ____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Health Information Manager of Lost Rivers District Hospital. Unless revoked, this authorization will expire in 180 days or on the following date or event: the_________ day of___________________, 20 ______.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and /or other sensitive information, I agree to its release. ف Yes ف No ______Initials

I understand that if my medical or billing record contains information in reference to HIV / AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ف Yes ف No ______Initials

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extend indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Lost Rivers Medical Center may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information disclosed.

I authorize Lost Rivers Medical Center to use and disclose the protected health information specified above.

Signature: ____Date:____________________________________

Identity of requestor verified by whom: _____________________

______Photo ID

______Matching Signatures

______Other:_______________________________________