

Lost Rivers Medical Center

551 Highland Drive
Arco, Idaho 83213
Ph. (208)252-7654
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. Yes 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. Yes 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 extent 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: _____