# Post Falls Family Medicine, PA

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## Authorization to Receive Medical Information

**Patient Name** (Please Print):_____ **Date of Birth**: _____

**Patient Phone**: _____

**RECEIVE RECORDS FROM**:

_____

**Phone**: _____ **Fax**: _____

**Information to be released:** (if not clearly defined, the most recent 2 years will be released)

- ☐ History & Physical **Date: ____/_____ (mm/yyyy)**
- ☐ Immunizations
- ☐ Post Op Report **Date: ____/_____ (mm/yyyy)**

**Most Recent**:

- ☐ Lab
- ☐ X-Ray
- ☐ Office Visit
- ☐ Other Information (Please specify) _____

**Purpose for which disclosure is being made: (please check one of the following)**

____ Attorney_____ Insurance _____ Doctor _____ Personal _____ Other _____

**EXCLUDE the following information from the records released (please initial)**:

____ Drug/Alcohol abuse/Treatment and diagnosis _____ Sexually transmitted disease
____ Mental Illness or psychiatric diagnosis and treatment _____ HIV/AIDS

**MY RIGHTS**:

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 the HIPAA regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed with this authorization. There may be a charge for these copies.

This authorization will automatically expire six months from the date signed or until the 3rd party payer claim is secured. I understand that I may revoke this authorization any time except to the extent that action has been taken in relationship thereon. To revoke this authorization I must submit my request in writing to Post Falls Family Medicine, P.A.

**Signed**: _____ **Date**: _____
(Patient, Guardian*, or authorized representative*)
*Please provide documents to prove authority to sign on behalf of the patient.

Possible copying fee required