AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

<u>All items on this authorization must be completed or the request will not be honored. Us "N/A" if not applicable</u>.

Patients Name: ______________________________

(insert street address)	(insert city, state and zip code)
Date of Birth (mm/dd/yyyy)	(insert phone number)

For this authorization, "My Health Information" means (check ALL that apply) and may <u>include</u> information regarding substance abuse treatment.

____Discharge Summary
____Outpatient Health Records
____Mental Health Records
____Psychosocial Assessment
____Progress Notes
____History of Allergies
____Diagnostic Test/Results
____Verbal Communication
____Drug & Alcohol Treatment Record
____Admission History & Physical
____Psychological/Educational Report
____ HIV/AIDS
____Psychiatric Evaluation/Diagnosis
____Psychiatric Admission Note
____Emergency Room Record
____Pathology Report
____Immunization Record
____Other: ______________________

For the date(s) of service starting/ending : ______________________________
(insert date(s) of service requested)

I authorize **North End Psychiatry and Associates** to release my ☐ information to ☐ receive my information from

(Insert name of person, hospital, agency or program)	(insert phone and fax of provider)
(insert street address)	(insert city, state and zip code)

for the following purpose: ______________________________

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Idaho guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, My Health Information will not be disclosed as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: ______________________. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization t the Health Care Provider identified above that provided the health information.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug & alcohol abuse, etc.

Signature of Patient **ONLY**: ______________________________ Date: ______________ (Required)

If you are **NOT** the patient but are signing on behalf of the patient complete the following:
I, ______________________________, confirm that I am the legal appointed representative for the patient and I have **CIRCLED** my relationship to the patient below:

Parent with Parental Rights	Registered Kinship Care Representative	Medical Power of Attorney	Court Appointed Guardian	Legally Appointed Healthcare Agent

Representatives Signature: ______________________________ Date: ______________ (Required)

Address: ____ Phone:____________________________________

<u>You must provide proof of your authority to act on behalf of the patient as circled above (other than parent).</u>