AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization allows the release of confidential medical records to Advanced Specialty Care For Women.

Patient Information

Patient Name _____ *Date of Birth* _____

Street Address _____

City _____ *State* _____ *Zip* _____

Phone _____ *e-mail* _____ *Fax* _____

TO: Healthcare Provider or Facility

Name of MD or Medical Facility _____

Address _____

City _____ *State* _____ *Zip*_____

Phone _____ *Fax* _____

Purpose of Records/Medical Information Release: _____

Please RELEASE my medical information to:

Advanced Specialty Care for Women
16111 N. Brinson St. Suite 110, Nampa, ID 83687
Phone: 208-468-9400 Fax: 208-468-9447 e-mail:
reception@nampaobgyn.com

Authorization

I hereby authorize the above healthcare provider or facility to release information regarding my medical history, illnesses or injuries; consultations, prescriptions, treatments, diagnoses or prognoses; including images, correspondence and/or medical records; by means of mail, fax or other electronic methods.

I authorize the release of the information specified below:

- ☐ My health information related to drug/alcohol/substance abuse.
- ☐ My health information related to psychological/psychiatric/mental health.
- ☐ My health information related to HIV/AIDS/STD diagnosis and/or treatment.
- ☐ My health information related to the following treatment or conditions:

- ☐ All my health information including substance abuse, mental health and HIV/AIDS/STD related.

Duration: This authorization is effective immediately and will remain in effect until _____
Date

Restrictions

Permissions for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

_____ / _____ / _____

Signature of Patient *(or legal representative)* Patient name (print) Date