



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION-IN

Full Name of Patient (Please Print): _____

Patient's Date of Birth: _____ Social Security Number: _____

Address: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED IS:

- ☐ ALL HEALTH CARE INFORMATION in the medical record
- ☐ Health care information in the medical record related to the following treatment or condition: _____
- ☐ Health care information in the medical record for the date(s): _____
- ☐ Other: _____

EXCLUDE the following information in the records released (If not marked, this information will be shared):

Psychotherapy Notes _____ Drug and/or alcohol use _____ Sexually related matters _____ HIV (AIDS virus) _____
 Other (specify) _____

The information will be used/disclosed for the following purposes:

Transfer of Care _____ Going to Specialist _____ Insurance Purposes _____
 Personal _____ Legal Purposes _____ Other (specify) _____

I request and authorize: Clinic/Provider/Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	To release my records to: Coeur d'Alene Pediatrics 700 W. Ironwood Drive, Suite 155 Coeur d'Alene, ID 83814 Phone: (208) 667-0585 Fax: (208) 625-2075
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I understand that there may be a charge for this service, and I agree to pay said charge on demand.

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 redisclosed and no longer protected by these regulations. I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. If Coeur d'Alene Pediatrics is asking to use/disclose my information, I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Expiration: This authorization expires on this date or event: _____. I understand this authorization will expire 90 days from the date signed if no specific expiration date is indicated. The authorization may be revoked by notifying Coeur d'Alene Pediatrics in writing at any time except to the extent action has been taken prior to revocation.

Signature: _____ Date: _____

Relationship to Patient: _____ Phone Number: _____

Date Received: _____	Date Released: _____	(Mail _____ In Person _____)	Initials: _____
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Coeur d'Alene
 700 W. Ironwood Drive, Suite 155
 Coeur d'Alene, ID 83814
 Phone: (208) 667-0585
 PHI Fax: (208) 625-2075

Post Falls
 1300 E. Mullan Avenue, Suite 1000
 Post Falls, ID 83854
 Phone: (208) 777-1330
 PHI Fax: (208) 625-2075

Hayden
 9095 N. Hess Street
 Hayden, ID 83835
 Phone: (208) 772-8940
 PHI Fax: (208) 625-2075