IDAHO UROLOGIC INSTITUTE

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SCI SURGERY CENTER OF IDAHO

Authorization to Release Medical Records

Patient: _____ **DOB:** _____

Patient Phone #:_____

This is to authorize that copies of medical records regarding the above stated patient be released.

From: Idaho Urologic Institute &
Surgery Center of Idaho
2855 E. Magic View Drive
Meridian, ID 83642
Phone: 208-639-4900
Fax: 208-639-4901

To:_____

Address:_____

_____

Phone: _____

Fax: _____

Please Indicate: Pick up:_____ Mail:____ Call:____

Need By:_____

I authorize the release of photocopies of the following medical records in the possession or control of the above named "From Physician", to be sent to the above named "Send to". FOR THE PURPOSE HERE-OF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661). CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 42 CFR SECTION 2.1 ET SEQ) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

□ All records
□ All records for the past _____ year(s)
□ Radiology reports
□ Other _____

□ Pathology reports
□ Surgery reports
□ Lab work

This information for which I'm authorizing disclosure will be used for the following purpose: _____

_____

I have given my consent freely, voluntarily and without coercion. I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form, unless it is for research-related treatments.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws and regulations.

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 Idaho Urologic Institute/ Surgery Center of Idaho. Unless revoked; this authorization will expire on the following date or event _____, or 60 days from date of signature, unless otherwise specified.

I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature Date