Eastern Idaho Public Health
Prevent. Promote. Protect.

Authorization to Release Information

Client Name: _____
Last First Middle Initial

Former Name(s): _____ Date of Birth: _____

I hereby authorize:

Healthcare Provider/ Individual: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

To disclose the protected health information described below to:

Healthcare provider/ Individual:_____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

The authorization release of information covers the period of healthcare from:

☐ (date)_____ TO (date) _____ **OR** ☐ All past, present, or future periods

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize only the following health records to be released:

☐ Immunization Record ☐ Pathology & Labs Reports ☐ Pap Reports ☐ Billing/Payment

☐ Other (Specify): _____

I understand that:

- This medical information may be used by the healthcare provider or individual I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purpose as I may direct.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I have the right to revoke this authorization, in writing, at any time, and authorization shall be in effect until EIPH receives written revocation. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____

Printed name of client or personal representative and his or her relationship to client

_____

Signature of client or personal representative **Date**