

Idaho Falls Pediatrics

3067 Eagle Drive, Ammon, ID 83406 1645 Pancheri Dr., Idaho Falls, ID 83402



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Medical Record Release

Authorization to release medical information and/or medical records

Patient Name:		of Birth		
I authorize Idaho Falls Pediatrics to	use or disclose Protecte	ed Health Informat	ion (PHI) conta	ained in my Medica
Records in the following manner:				
To:				
Person/Institution requesting data	Fax #			
Street Address	City	State	Zip	Phone
From: Idaho Falls Pediatric	s, 3067 Eagle Driv	e, Ammon, ID	83406	(208) 522-46
Doctor's name	City	State	Zip	Phone
Please Release the following	Protected Health	Information:		
All Records	Chart Notes	_ X-Rays	Labs	Mental Hea
Other (please specify)	:	•		
(List amasi	Go mumosos the Duetoeted	Haalth Information	vill be utilized)	
(List speci	fic purposes the Protected	Health Information v	viii be utilizea)	
Expiration date of release				
This authorization is effective thr	ough / / unle	ss revoked or teri		
guardian.	· · · · · · · · · · · · · · · · · · ·		ninated by the	e patients parents o
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I understand that I have the right to	revoke this authorization		-	-
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